Melbourne School of Population and Global Health

Centre for Health Policy

OPEN ACCESS SERVICES EVALUATION:

AN APPRAISAL OF FOUR OPEN ACCESS CENTRES IN MELBOURNE:

- Sacred Heart Mission
- St Mary's House of Welcome
- VincentCare Victoria (Ozanam Community Centre)
- UnitingCare Prahran Mission–St Kilda 101

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Executive Summary

This project aims to better understand the role of Open Access centres and how their services should adapt to meet the needs of their clients more effectively. A key goal of the project is to understand the types of participants who use these services. Four Open Access centres in Melbourne participated in the study: Sacred Heart Mission (both the main campus and the women's service) which is the lead agency involved in the project, VincentCare, St Mary's House of Welcome and Prahran Mission. All four agencies provide vital support and service delivery for people experiencing homelessness or who are at risk of homelessness, poverty and social exclusion. In particular, we seek to identify and analyse:

- who is using Open Access services;
- what services are being used and how they connect with other programs;
- the benefits of the services for participants and any unintended consequences;
- how service models may be optimised to improve client experiences.

This project is funded by the Lord Mayor's Charitable Foundation and has been approved by the University of Melbourne Human Research Ethics Committee.

A preliminary review of the literature to inform the project examined national and international research, identified gaps in studies focusing on Open Access centres and established the benefits and challenges experienced by clients who use them. Research methods used for this project were a quantitative survey of a sample of clients, 40 in-depth qualitative interviews with clients and observation of normal daily activity and interaction at centres.

In relation to the project's aims, the study's findings are as follows:

- Centre clients are characterised by high levels of past and present homelessness, with 80% of the survey sample either currently or previously homeless. Unstable accommodation, high levels of physical and mental health needs, and substantial physical and social isolation are common. Nearly all participants in the sample are dependent on social security benefits – particularly the Disability Pension – and are therefore on very low incomes. Clients are predominantly Caucasian, male and middle aged, with very few under 25; while demographic characteristics vary across the four centres.

- Survey and interview data indicate that clients rely heavily on core centre services including homelessness and housing support, crisis response and referral, allied health and counselling services, and social and sports programs. There appears to be strong in-house integration between services and programs, to the extent that many clients look to centres as a 'one-stop shop' for their service needs, as far as is possible. This may be less a choice of convenience and more one of necessity, for reasons of poverty and feeling unwelcome in mainstream society. There appears to be little transfer away from centre-based services and towards usage of mainstream services. However, this may be an artefact of the cross-sectional study design that only captures current clients at a point in time. A longitudinal study would be required to examine client transfer away from centre usage.

- All the findings point to improved quality of life in the domains of social inclusion, physical and mental well-being, housing (within the constraints of a severe shortage of affordable housing) and life skills. Improved economic circumstances appear to be unachievable for most clients beyond the savings they can make by using the centres' free or low-cost facilities and services, as the majority are on fixed income disability or age pensions. No unintended consequences are directly identified by the research data. Survey data indicate that the demand for support workers, service appointments, programs and activities, opening hours and quiet space/women-only facilities exceeds the resourcing capacity of the centres. However, the centres do appear to be meeting the most critical needs of their clients.

- Overall, the results demonstrate that the Open Access centres act as instruments of social inclusion for people who otherwise experience social and economic marginalisation. There is sufficient evidence to conclude that all the centres in this study function as multi-purpose community centres for their clients. The centres also offer much-needed services and facilities that their clients would not be able to access otherwise. In respect of this, the centres allow for visiting and co-located agencies to fulfil their mandates to service the most marginalised people in our society. In this way, Open Access centres play an integral role in community health and social security systems.

Recommendations

Recognising the value of Open Access services

This study has recognised the strengths and benefits of Open Access centres, and their role in preventing adverse outcomes for clients with complex needs and disadvantages. It found very little evidence of unintended negative consequences. Policy change on a number of fronts could impact on Open Access services and their clients. In this context, the value of Open Access services needs to continue to be recognised. The Open Access model of service itself should be promoted, highlighting its unique approach for members of society who are experiencing, or at risk of, homelessness. The fact that these spaces allow people access to meals, essential services and a place to belong without requiring anything of the client, including personal information, is a key feature of their service delivery.

Enhancing clients' social interactions and expanding or improving services and facilities

Recommendations for service and centre improvements fall into two categories: enhancing clients' social interactions, and expanding/improving services and facilities. To address the fact that many individuals within the sampled population experience social isolation, it is important to facilitate interactions among clients as well as with staff members. Continuing to encourage participation in activities and creating an environment conducive to social interaction is key to this. In addition, further incorporating client feedback into the improvement of services and facilities will continue to improve client satisfaction. These strategies can be expected to lead to better client outcomes. There is no evidence from this research that changing the overarching service models would necessarily lead to better client outcomes.

Developing systematic approaches to reducing safety threats

During the consultation phase of the project, workers at the Open Access centres identified a number of programmatic proposals (e.g. changing meal times) and client management proposals (e.g. screening and assessing attendee vulnerability) to help reduce potential safety issues. While extensive safety procedures exist at Open Access centres, the strategies used by centre staff to manage minor risks and incidents are seldom reported, including communication of these procedures between centres. A more systematic approach to documenting these strategies may be helpful in understanding their effectiveness and adjusting to changing client populations.

Promoting the role of Open Access centres in providing integrated care

The study showed that Open Access centres are seen as a 'one-stop shop' to meet their clients' needs. They provide a broad range of health – including allied health –and social services. Current reforms associated with the National Disability Insurance Scheme, aged care and mental health focus on the provision of integrated care. Open Access service leadership in this area should be highlighted, particularly for clients with complex needs. Therefore, it is important that the system be recognised as serving a dual purpose within the community:

1) Open Access services are leaders in integrated care, providing a one-stop shop for servicing client needs;
2) Open Access services support clients in reaching their full potential, encourage capacity building and enable clients to graduate from the system altogether.

Engaging with policy change

The National Disability Insurance Scheme (NDIS) aims to provide integrated care for people with disabilities under the age of 65, and encompasses reforms in aged care and mental health. Among clients in this demographic, 61% were on Disability Pensions. Of these, 10% reported a physical illness, 29% a mental illness and 40% both a mental and physical illness. These figures were 9.9%, 25.2% and 23.8% respectively for clients under the age of 65 who were not in receipt of a Disability Pension. This may suggest there are eligible clients who are currently not receiving benefits. Given the outcomes framework underpinning the NDIS, it would also be recommended that Open Access centres continue the process of developing their own outcomes frameworks and measure their impact on clients in order to be aligned with the policy changes.

Open Access centres need to ensure that all eligible clients are accessing new schemes and that these schemes are included as part of a client's care. It is also important to ensure that funding is not eroded to the extent that eligible clients are no longer able to receive care.

Client eligibility and funding implications associated with the NDIS are still unknown. However, consultation with Open Access centres in pilot sites may provide important insights, in order to better inform responses.

Introduction

The Open Access or 'drop-in' model of service for people who are experiencing or at risk of homelessness plays a significant role in engaging the most marginalised groups in our society, facilitating access to services alongside addressing homelessness, sustaining recovery and maintaining housing outcomes.

Australia is currently undergoing a major process of reform in the funding of social and community care. This has included major changes to the Health and Community Care (HACC) program and introduction of the National Disability Insurance Scheme (NDIS). NDIS has been implemented in stages and commenced operation on July 1, 2013. The National Disability Insurance Agency (NDIA), which was formally known as DisabilityCare, is the government agency responsible for the NDIS (Mendoza, 2013). The NDIS is scheduled to be rolled out progressively in Victoria over a three-year period from July 2016 (DHS, 2016). By July 2019, it is estimated that 105,000 Victorians will have transferred to the scheme. The policy affects people currently receiving disability support, and some who are receiving Home and Community Care Services (under the age of 65) and Mental Health Community Support Services (MHCSS) (DHS, 2016).

In addition to the reforms associated with aged care, significant changes have emerged in the mental health sector as the government-funded MHCSS transitions into the NDIS. According to Victoria's 10-year mental health plan, "The NDIS will significantly increase the number of Victorians with psychosocial disability who receive support, and change the way support is provided. The range of support services available will be far wider, and Victorians with psychosocial disability support needs will be able to choose the support and services they receive to meet their individual needs" (DHHS, 2015). However, questions have been raised by not-for-profit organisations previously responsible for the delivery of the MHCSS about the incorporation of mental health services into the NDIS. Of particular concern were both the shift to the consumer-driven model and the fact that Victoria is the only state in Australia that plans to transfer all funding for specialist mental health community support and rehabilitation services into the NDIS (MI Fellowship, 2016).

At the same time, Open Access services have experienced decreased funding in the context of mental health reform, and their role in this changing landscape is increasingly unclear. This has created an imperative to better understand the role of Open Access services in providing care to vulnerable populations and how the services should adapt to better meet the needs of their clients.

Our research partnership consists of significant service providers in the provision of Open Access services, including Sacred Heart Mission (two services) as the lead agency, VincentCare (one service), St Mary's House of Welcome (one service) and Prahran Mission (one service). These partnerships will assist with the recruitment of people who are homeless, or at risk of becoming homeless. Our focus is to understand who uses the Open Access service, what kind of services are being offered and accessed, and how these services connect with other programs. We also aim to identify and understand the benefits accrued by those using the Open Access service and identify any unintended consequences of visiting them.

A key aim of the project is to understand the types of participants who use these services. All four partner agencies operate Open Access-type services within Melbourne for people experiencing homelessness or who are at risk of homelessness, poverty and social exclusion.

The Open Access services

Sacred Heart Mission

Sacred Heart Mission assists those who are experiencing a range of complex issues, such as homelessness, chronic health conditions, mental illness, long-term unemployment, social isolation, substance abuse and trauma. It works to build people's capacity to participate more fully in community life by addressing the underlying causes of deep, persistent disadvantage and social exclusion.

SHM operates two Open Access services, Sacred Heart Central and the Women's House, both located in the inner-city area of St Kilda.

The services include a meals program, resource room duty service, crisis intervention, intensive case management, pathways to economic participation, complementary health services, a GP clinic, short-term crisis accommodation for women, a supported rooming house for people with long-term homeless and complex needs, in-home support enabling the frail and elderly to remain in their own homes and residential aged care. Through on-site partnerships the organisation also provides alcohol and other drug support and linkages to mental health services and case management.

The meals program is open every day of the year and serves about 175,000 meals annually.

UnitingCare Prahran Mission–St Kilda 101

The St Kilda 101 Engagement Hub is a program for adults experiencing severe and enduring mental ill health. It offers an open, accessible and welcoming space and a non-stigmatising environment for its participants, staff, carers and volunteers. The 'drop-in' elements, which some of our participants find essential since they are difficult to access elsewhere, include the meals program, laundry and shower facilities, and a space to chat and relax. Funding is provided through donations and local and state government sources. Individual Client Support Packages funded through MHCSS are also provided on site. The soft entry, open-door approach potentially enables a more effective strength-based participant journey.

The St Kilda 101 Engagement Hub also provides strength-based Planned Activity Groups (PAGs). These include drama, cooking, art, gardening and a women's group. The hub also offers participants a deeper level of engagement than traditional 'drop-in' supports, and participant involvement in the planning and delivery of these groups is actively sought. The groups support social inclusion, community participation and the enhancement of people's independence, through engagement with their skills and desires. Further exploration of participants' situations, needs and goals emerges organically from participation in groups, which provide opportunities to supporting people in accessing the more formalised Individualised Client Support Package.

The St Kilda 101 Groups Program provides a safe and inclusive space for adults experiencing severe and enduring mental ill health to engage in a range of activities and supports. These are designed to

address barriers to independence and community participation, which mental illness can produce. The program offers participants a platform for socialisation and for accessing activities and experiences they otherwise may not. It also provides the opportunity to develop skills and knowledge in specific areas, as identified by participants, so that they may increase their independence and well-being and achieve their recovery goals.

St Mary's House of Welcome

St Mary's House of Welcome (St Mary's) is an Open Access centre for some of the most marginalised and disadvantaged people facing poverty, homelessness, drug and alcohol problems, social isolation and mental health issues. It is located in the inner suburb of Fitzroy. St Mary's offers various supports and services for service users accessing both the Open Access centre and structured mental health programs and activities.

The St Mary's Open Access centre provides a safe and welcoming space in a community setting. Services include a meals program, access to showers and hygiene products, and emergency relief, plus information about and referral to more specialised community and clinical services including legal, housing, financial counselling, mental health and drug and alcohol support.

The structured activities and programs offered through its mental health services focus on eight main areas of an individual's life; in-house activities, recreational, work/education, social and special events, CALD-specific groups, cross-cultural outings and key worker support. These services are designed to reduce social isolation and encourage positive relationships and a greater sense of inclusion in the community. St Mary's meal program provides in excess of 40,000 meals annually and provides over 30,000 episodes of support to those most in need.

VincentCare Victoria (Ozanam Community Centre)

Ozanam Community Centre is part of VincentCare Victoria's Inner Melbourne Community Hub. The centre provides holistic support to men and women who are homeless and/or disadvantaged, aiming to provide a consistent, safe and comfortable environment for all. For some of the most marginalised and isolated people who are unable to access mainstream services, Ozanam Community Centre provides a sense of community and a diverse range of housing, health and welfare services in collaboration with sector partners on an ongoing basis. The centre facilitates engagement with a wide range of internal and co-located external services, aiming to generate stable and sustainable living, autonomy, well-being and community connectedness.

On-site services include initial assessment and planning (housing response), alcohol and other drugs counselling, intensive case management, financial counselling and capacity building and a client volunteer program. Service partnerships include Centrelink, Inner Melbourne Legal Service, Inner West Outreach Alcohol and Other Drugs, CoHealth: podiatry clinic and dietitian, Homeless Persons Program (RDNS), homeless person's dental clinic, optometry clinic, GP clinic and gamblers help.

The Open Access program provides two meal services a day (breakfast and lunch) for up to 200 people, tea and coffee facilities, shower and laundry facilities, a postal service, storage space, library area and computer access. Planned activities include a music program, art therapy and recreational activities.

Aims

The Open Access or 'drop-in' model of service for homeless people plays a significant role in engaging some of the most marginalised members of society. It facilitates access to services as well as addressing homelessness, sustaining recovery and helping maintain housing outcomes. Open Access services also create conditions that enable positive social and cultural exchange and inclusion.

In general, Open Access services are characterised by an 'open-door' policy where each person is welcomed to access the available services without assessment of need, without obligation to contribute information about themselves or their situation, and generally, without an appointment. Services offered may include meals, showers, clothing, practical advice and support, medical and mental health support, information and advice, all provided in a safe and supportive environment that facilitates connection and support. It is understood that meeting basic needs creates sufficient relief from immediate pressures, enabling participants to consider other aspects of their circumstances (Meagher, 2008).

The primary intent of the Open Access model of service is to, over time, engage the person in a trusting relationship with the service that provides a purposeful opportunity to introduce them to more structured services and support. Free or subsidised meals are often provided by Open Access centres as a primary engagement tool for those who otherwise would not access services. More formalised services may include skill building, support groups, recreation activities, individualised support and advocacy through case management, referrals to other service providers for specialised services (such as substance use programs) or other services not provided by the organisation (crisis accommodation, transitional housing or supported housing).

This project brings together significant service providers in the provision of Open Access services including Sacred Heart Mission (two services) as the lead agency, VincentCare (one service), St Mary's House of Welcome (one service) and Prahran mission (one service).

This study explores people's experiences of Open Access services and aims to identify and analyse:

- who is using Open Access services;
- what services are being used and how they connect with other programs;
- the benefits of the services for participants and any unintended consequences; and
- how service models may be optimised to improve client experiences.

Literature Review

Background: What are Open Access Centres?

Open Access centres are an important resource for homeless and marginalised people. They are a place where the socioeconomically deprived can go to socialise, shower and obtain social assistance, as well as important sustenance (Healthcare, 2016). They attempt to counter many of the daily stressors of homelessness and poverty in a physically, socially and emotionally safe place that minimises the triggers for each client. They have the potential to facilitate engagement of homeless people into treatment and connect them back into mainstream services (Slesnick et al. 2008). They generally adopt a non-institutional approach, in contrast to traditional mental health or social service institutions, offering a range of services that rely on models of self-help and self-empowerment (Brenton in Grella, 1994). Key aims include:

1) improving the pervasive social isolation experienced by homeless and marginalised people;
2) promoting their learning of social skills; and
3) building self-efficacy and self-esteem.

The centres provide a supportive environment and caring staff, as well as a loose and flexible structure. This allows them to cater to the needs of those with a history of victimisation, fear and distrust of others, and mental health problems, gradually integrating them into social service programs (D'Ercole and Struening, 1990 in Grella, 1994).

Open Access centres are highly varied in terms of their type, stated goals, funding arrangements and service provision. According to the literature, however, Open Access centres tend to adopt one of three approaches. The first approach is the spiritual/missionary approach that asks little of clients. The Open Access centre is created as a sanctuary that offers acceptance, tolerance and containment. The second model is a social work approach that provides a place of rehabilitation and change for its clientele. Here, participants are encouraged to change their circumstances through the targeted interventions being offered. The third model is a community development approach. This model looks to empower individuals and attempts to support clients in utilising their own and their peers' resources (Meagher 2008). Drop-in centres in Victoria tended to emanate historically from the first approach, and can be seen to have developed into the second and third models.

A common feature of all models is the focus on improving stability for participants, particularly in areas of housing and income (Meagher, 2008). The literature mostly focuses on the second type of model, and this formed much of the basis of this review. The types of services vary in terms of provision. Some offer very basic services such as food and shelter, while others provide more complex multi-service offerings (Meagher, 2008). The benefits of Open Access centres can be constructed as the proximal benefits arriving from services that arise from the Open Access context. In addition, more distal benefits associated with connecting people with community and other services are garnered. As Meagher points out, ascertaining the success of such programs is challenging given the long-term nature of objectives that occur only in the last stages of service. Thus, while obtaining a sense of the incremental progress that is typical of participants is important,

it is difficult to capture (Meagher, 2008). Meagher advances that while this model dominates thinking in the literature, it is limited and can be misleading. Analysis of primary research points to the fact that most Open Access centres subscribe to two aspects of the models, and some work within all three in some way. He argues that these models can be better understood as "elements of a spectrum of services that Open Accesss provide, with each Open Access centre covering some portion of that spectrum" (Meagher 2008).

Service Provision

Attendance at Open Access centres is generally difficult to ascertain given the anonymous nature of service provision. De Rosa's (1999) youth-specific study found that while determining the specific numbers of attendees was difficult, 78% of homeless youth reported accessing services at Open Access centres, compared with only 40% at shelters. Thus, Open Access centres play a vital role in the provision of services, including food, clothing, showers and laundry (Slesnick, Kang, Bonomi, and Prestopnik, 2008) as well as other types of provisions, to facilitate the life experiences of homeless people. These may include:

1. Basic sustenance:
    - The ability to obtain food

2. Social inclusion:
    - The ability to form and retain relationships
    - Increases in the range and type of relationships
    - The strengthening of interpersonal skills
    - Improved communication skills
    - The ability to be realistic
    - The ability to express emotions appropriately
    - The ability to manage conflict
    - Acknowledging others
    - Decreases in temper or violence
    - Reductions in self-harmful and reckless behaviour
    - Reduction of drug or alcohol use

3. Health:
    - The ability to sustain physical health
    - Improved mental health
    - Improvements in memory and mobility
    - Psychological and cognitive benefits (minimising confusion and disturbing thoughts; improvement in concentration)

4. Financial independence:
    - The ability to find work
    - The ability to manage money

5. Life skills:

- The ability to manage day-to-day life
- The ability to manage household responsibilities
- The ability to complete tasks
- Pursuit of educational and recreational activities
- Daytime activities, and the extent to which such activities were deemed 'useful'
- The development of self-confidence
- The development of independence and autonomy
- Motivation
- Goal setting
- Increases in satisfaction and in access to information

(Meagher, 2008)

Mental Health

Much of the literature on Open Access centres focuses on the mental health status of homeless people in attendance. Tsemberis et al. (2003) show how centres provide opportunities for individuals experiencing serious mental illness, given their propensity to be faced with many negative outcomes including depression, frequent hospitalisation, suicidal behaviour, dysfunctional family relationships, victimisation and abuse (Tsemberis, Moran, Shinn, Asmussen, and Shern, 2003). Demographic analysis of Open Access centre clientele suggests that clients attending Open Access centres are likely to have active substance use problems, histories of violence, prison records, histories of refusing treatment and idiosyncratic or problematic behaviours (Tsemberis et al., 2003). These predicaments are exacerbated for those living on the streets. Yet, in spite of their multiple needs, programs report extreme difficulty engaging this population in traditional services. Open Access services are specifically designed to address the reasons that individuals living on the streets with severe mental illness may be reluctant to engage in the traditional programs designed to assist them (Tsemberis et al., 2003).

Safety

A common goal of all Open Access centres is the provision of a safe, warm and welcoming environment. The issue of safety was not a primary area of focus of many studies, with the exception of perhaps Johnsen et al. (2005). However, it was a commonly occurring minor theme, particularly in articles talking about vulnerable populations' use of Open Access centres. The matter of safety was mentioned frequently as being important for both staff and clients. Open Access centres tend to be located in "run-down inner-city areas characterised by high levels of crime, prostitution and illicit drug use" (Johnsen, Cloke, and May, 2005). This presents issues concerning the safety of both staff and service users who traverse such spaces to access Open Access centres. Further, according to Johnsen et al. (2005), the stigma around these types of urban locales tends to reinforce negative perceptions regarding the value of individuals needing to use the services at a time when their feelings of self-worth are already low (Johnsen et al., 2005). With respect to concerns for staff, as Johnsen et al. (2005) advance, "centre providers are resigned to the fact that they may (indeed are highly likely to) encounter dirty or ill bodies, unpredictable behaviour and the trappings of lifestyles revolving around drug dependency. Although incidences of theft, violence or disposal of drug-related 'gear' on the premises tend to be few and far between, these are realities that the majority of day centre managers face at some stage in the course of their work".

The idea of public space was an important subtheme to emerge in the work of Johnsen et al. (2005). These authors show how literature on public policy points to the fact that homeless people are increasingly rendered 'out of place' in public areas as a result of their presence 'disturbing' the aesthetics of the urban environment. The inclusion of homeless people into what has been described as 'prime' city space (Duncan 1983) becomes a point of concern for wider society, as the supposedly 'spoiled' identities (Goffman 1968) of homeless individuals might in some way contaminate such spaces and, by extension, the identities of others using those spaces (Johnsen et al., 2005). This has led to the development of punitive policy measures targeting those experiencing homelessness in a number of cities across the USA, Canada and Britain. As a result, measures to control and contain the activities and movements of homeless people can be witnessed (Johnsen et al., 2005). This has led to an increasing focus by urban geographers concerning the rise in charitable care available to those experiencing homelessness, exemplified by night shelters, hostels and Open Access centres that have emerged to provide basic support services. Thus, the importance of Open Access centres in creating a refuge or sanctuaries for homeless people is apparent.

Literature Review Methods

The purpose of the literature review is to examine national and international research to situate the project and examine the gaps in studies focusing on Open Access centres. Specifically, the study sought to establish the benefits and challenges experienced by clients who use Open Access centres. Of particular interest were studies that considered the impacts of Open Access centre services and theory underpinning these facilities. A search using the key terms 'drop-in' (and naming varieties) and 'evaluation' and 'homeless', using *Search Discovery*, obtained 130 hits. From that, a manual search produced 19 hits that were within scope. A more systematic approach was also developed with the help of a librarian using a similar version of the search terms used in Meagher's (2008) paper. However, the study was not replicated exactly, and certain parameters were omitted given their lack of relevance; for example, identity markers such as 'native people', 'people of colour' and so forth were not included as qualifying terms. The following search strategy was employed in Sociological Abstracts, Social Services Abstracts, ERIC, CINAHL, Academic Search Complete, Web of Science, Medline and PsycINFO:

Table 1: Search strategy

("drop in" or "drop-in" or "drop ins" or "drop-ins" or "day centre*" or "day center*") and homeless*
AND
"evidence based practice*" or "good practice*" or "best practice*" or measure* or evaluate* or outcome* or resettle* or pathway* or "secure* housing" or "social network*" or "social support*" or "find* housing" or "community building" or "community development" or outreach or "settlement service*"

Articles were coded initially to ascertain their relevance to Open Access centres. Studies chosen for in-depth analysis presented either a benefit or a challenge to Open Access centres (the organisation, staff or clientele). The benefits described by the literature included service provision, access to housing and skills development; while the major challenge discussed was funding. Because of the nature of the studies and the wider literature they form part of, their relevance varied. The following

table describes the inclusion characteristics for the specific benefits or challenges outlined in the literature.

Table 2: Inclusion criteria explained for benefits/challenges themes

Theme	Benefit	Challenge	Inclusion criteria
Healthcare interventions	**X**		A study was deemed relevant if an intervention was focused on health and discussed an impact to the target population.
Housing	**X**	**X**	This category was more descriptive. Any study mentioning housing in its abstract was included to get a sense of clients' experience of housing. Studies were deemed irrelevant if they were simply referencing another study in the sample.
Skill development	**X**		A study was deemed relevant if an intervention was focused on the development of skills for drop-in service clientele and included an impact.
Funding		**X**	Any study that discussed funding in its abstract was included.

There was some overlap across categories. For example, some skills development programs had an impact on housing attainment (Nelson, Gray, Maurice, and Shaffer, 2012) or the provision of services such as housing assistance and client satisfaction (Sosin, George, and Grossman, 2012). Other literature reviews or systematic reviews were not used for the analysis, but helped inform the background or methods.

The grey literature was also reviewed following the recommendations of the advisory committee and conducted using a hand search. Studies of this nature were only included if they fitted the inclusion criteria.

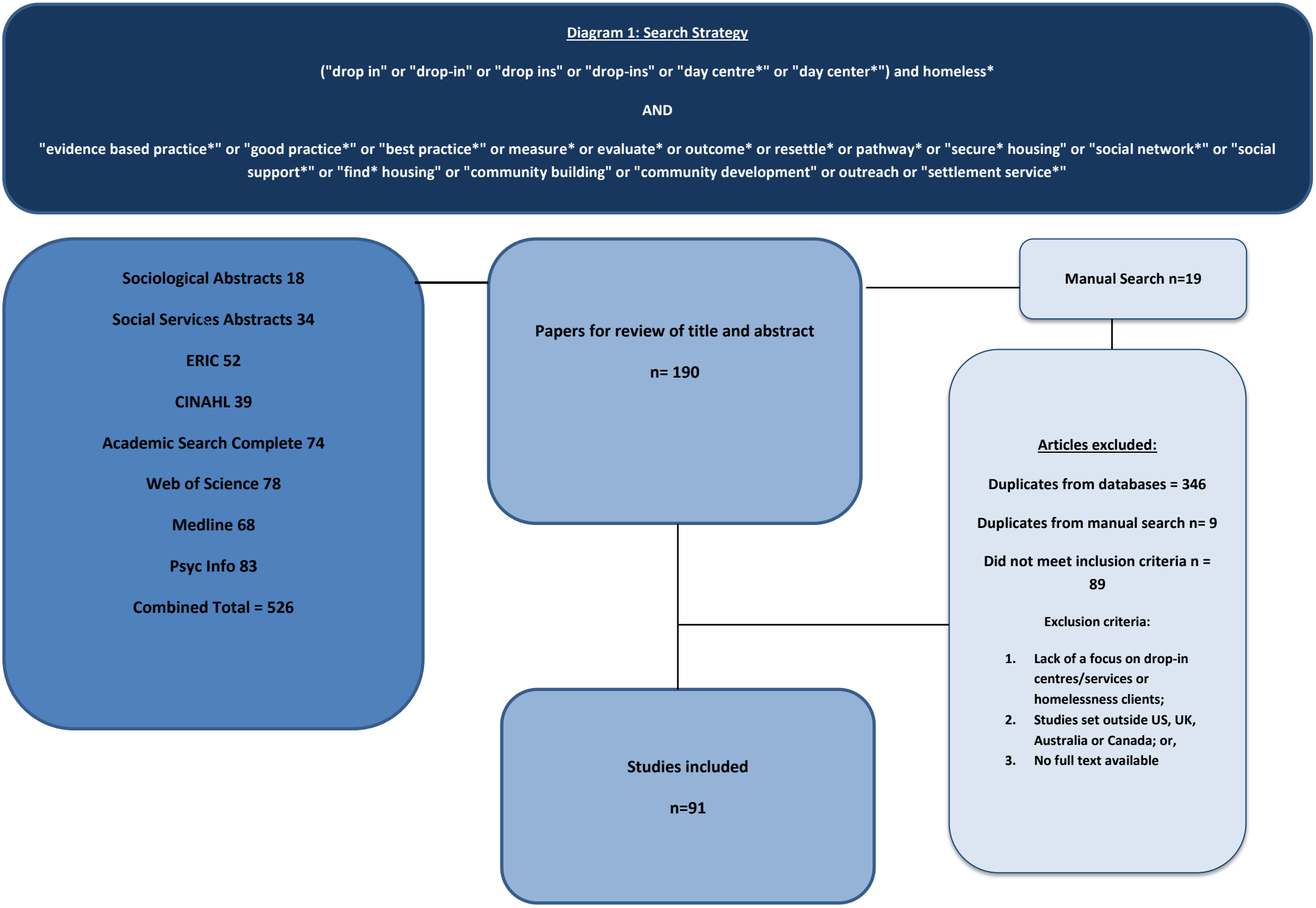


Diagram 1: Search Strategy
("drop in" or "drop-in" or "drop ins" or "drop-ins" or "day centre*" or "day center*") and homeless*
AND
"evidence based practice*" or "good practice*" or "best practice*" or measure* or evaluate* or outcome* or resettle* or pathway* or "secure* housing" or "social network*" or "social support*" or "find* housing" or "community building" or "community development" or outreach or "settlement service*"
Sociological Abstracts 18
Social Services Abstracts 34
ERIC 52
CINAHL 39
Academic Search Complete 74
Web of Science 78
Medline 68
Psyc Info 83
Combined Total = 526
Papers for review of title and abstract
n= 190
Manual Search n=19
Articles excluded:
Duplicates from databases = 346
Duplicates from manual search n= 9
Did not meet inclusion criteria n = 89
Exclusion criteria:
1. Lack of a focus on drop-in centres/services or homelessness clients;
2. Studies set outside US, UK, Australia or Canada; or,
3. No full text available
Studies included
n=91

Literature Review Findings

Benefits

Healthcare interventions

Since suspicion of authorities and institutions can be a barrier to engagement into health service treatment, many studies have found it critical that the engagement process begin in a safe, non-threatening environment (Zerger, 2002). Health was one of the most frequent issues written about in the literature on Open Access centres, with more than 50% of articles having a health focus according to an analysis of abstracts. Many health promotion interventions that target people experiencing homelessness, ranging from sexual health safety (Dasari et al., 2016; Martino et al., 2011; Tucker et al., 2012; Winetrobe et al., 2013) to dietary patterns and food sources (Evans and Dowler, 1999; Tarasuk, Dachner, and Li, 2005) to cancer screening (Heyding, Cheung, Mocarski, Moineddin, and Hwang, 2005), take place in Open Access centres. Bantchevska et al. (2011) discuss how homeless people comprise a vulnerable and disenfranchised group who experience social exclusion and inadequate access to health and social services, and are at greater risk of violence, sexual assault and other trauma. Specific subgroups, such as youth, are even more vulnerable. Therefore, the use of Open Access services as a means to engage marginalised communities in health services was a focus of the literature (Bantchevska et al., 2011). Aside from the frequent theme of health benefits, the qualitative study by Biederman, Nichols, and Lindsey (2013) revealed the theme of being 'cared for' and social support – in contrast to routine support – is important to participants' experience of service provider encounters (Biederman et al., 2013).

Of the 91 articles found within scope, according to an abstract search, 17 articles explored various types of interventions. Of these 17, a further 12 explored whether Open Access centre interventions have direct impact in terms of health promotion initiatives. The types of interventions being evaluated included:

1) individual-focused therapies such as brief motivational interventions;
2) community reinforcement approaches, and knowledge and skills training;
3) broader interventions such as family therapy, support groups; and,
4) shelter-based health care and housing programs.

All 12 studies reported statistically significant or other incremental benefits of treatment services obtained in Open Access centres compared to pre-intervention figures. This supports other literature reviews that analyse existing evidence on interventions. For example, Xiang (2013), examining specifically the issue of substance use problems among homeless youth, found that participants reported improvements in substance use outcomes over time in most of the studies. However, as this study found, ascertaining the superiority of a specific intervention is difficult to determine. This is because of the heterogeneity of the interventions and the fact few studies have been conducted on each intervention (Xiang, 2013). Although, implications for practice and research were frequently a point of discussion (Xiang, 2013).

Some of the types of examples of successful interventions include Magee and Huriaux (2008) who look at a women-specific 'Ladies' Night' program in an Open Access centre. Their study found the

program was successful in reducing harm, fostering positive change and promoting health, despite the challenges of the social context of participants' lives and resource limitations affecting service provision (Magee and Huriaux, 2008). Slesnick et al. (2009) explored the impact of community-based services and treatment interventions designed to intervene in the lives of runaway and homeless youth. They found that homeless youth can be engaged into treatment and respond favourably to intervention efforts. Heyding et al. (2005) looked at a breast screening intervention for homeless and mentally ill women. They showed how there was an increased use of mammography in a group of disadvantaged women who were clients of an inner-city Open Access centre.

Table 3: Summary of articles exploring health care interventions in Open Access services

Author	Intervention type	Target demographic	Country	Outcome
Booth et al. (1999)	To assess HIV-related drug and sex risk behaviours and evaluate factors associated with change in risk behaviours	Runaway and homeless adolescents	USA	Logistic regression and analysis of covariance revealed that, compared to the control group, the intervention significantly increased participants' HIV knowledge.
Cunningham et al. (2007)	Medical outreach program targeting unstably housed	HIV-infected individuals	USA	Patients kept appointments more frequently when they were walk-in or same-day appointments (compared with future appointments), when they were at a community-based organisation's Open Access centre (compared with single-room occupancy hotels, or when made by non-medical providers. These findings demonstrate the importance of program-related characteristics in health services' delivery to marginalised populations.
Heyding et al. (2005)	Breast screening	Homeless and mentally ill women	Canada	Increased use of mammography.
Magee and Huriaux (2008)	Ladies' Night program: women-specific services	Women	USA	The program provides safety and social support for participants, fosters positive change and promotes health.
McCay et al. (2015)	A 12-week Dialectical Behaviour Therapy (DBT) intervention across two Canadian service agencies providing Open Access, shelter and transitional housing to street-involved youth in order to alleviate mental health challenges and to strengthen resilience	Street-involved youth	Canada	Overall results demonstrate that youth who received the DBT intervention showed significant improvement in mental health challenges (e.g. depression, hopelessness, and anxiety), as well as significant improvement in resilience, self-esteem, and social connectedness immediately post-intervention. Participants in the wait-list control did not demonstrate significant improvement on any of the study outcome measures.

Norton et al. (2014)	Community-based Hepatitis C Virus screenings	Women's Open Access centre attendees	USA	On-site educational intervention improved both knowledge and acceptability of HCV testing and care.
Slesnick et al. (2007)	Comprehensive intervention for homeless, street-living youth that addresses substance use, social stability, physical and mental health	Homeless youth	USA	Youth can be engaged into treatment and respond favourably to intervention efforts.
Slesnick et al. (2008)	The impact of case management and individual therapy offered through a drop-in centre for homeless youth on substance use, mental health, housing, education, employment, and medical care utilisation	Homeless youth	USA	Statistically significant improvements were found in substance abuse, mental health, and percentage of days clients that were housed, up to 12 months postbaseline. Decreased alcohol and drug use was associated with an increase in housing. However, most youth did not acquire permanent housing, and education, employment, and medical service utilisation did not significantly change over time.
Slesnick et al. (2009)	Community-based services and treatment interventions	Runaway and homeless youth	USA	Homeless youth can be engaged into treatment and respond favourably to intervention efforts.
Slesnick et al. (2016)	Engagement in services at shelters, clinics, Open Access centres and other programs.	Homeless youth	USA	Findings indicated that youth prefer Open Access centre services to the shelter. The Open Access centre linkage condition was associated with more service linkage overall and better alcohol and HIV-related outcomes than the shelter linkage condition.
Story et al. (2014)	Influenza vaccination	Homeless adults	UK	A cross-sectional survey was carried out in 27 separate homeless hostels, day centres and drug services. Uptake of vaccination in homeless 16 to 64-year-olds with a clinical risk factor during the 2011/12 influenza season was 23.7% (95% CI: 19.8, 28.3) compared to national levels of 53.2% (excluding pregnant women).
Tucker et al. (2012)	HIV prevention program	Homeless youth	USA	More positive condom attitudes and access was needed.
Xiang (2013)	Substance use problems	Homeless youth	USA	Participants reported improvements in substance use outcomes over time in most of the studies.

Housing

Pathways to housing (or conversely, out of housing into homelessness) as well as the housing status of clientele were two key issues discussed in the literature. Sixteen articles had this theme as a focus of their study. It was shown that Open Access centres facilitated reintegration goals by providing

access to a social services worker or use of community services. These factors were more likely to ensure an exit out of homelessness. On the other hand, looking at pathways to homelessness, Butler and Weatherley show how pivotal issues such as relationships, resilience to hardship and attempts to maintain normalcy are key issues for the women they interviewed in their research sample. Their study demonstrated that interviewees tended to describe their experiences without self-blame, yet displayed an awareness of the discrimination they encountered (Butler and Weatherley, 1995). The authors suggest that definitions of homelessness are arbitrary, and a lack of adequate policies on income and housing perpetuates the problem (Butler and Weatherley, 1995).

In the discussion of housing, only one study provided a comparative approach to understanding services that facilitated transitioning to housing. Open Access services were shown to positively impact clients' experiences of attaining housing. However, McBride et al. (1998), in their exploration of predictors of the duration of homeless spells, found that people who received assertive community treatment exited homelessness more expediently than individuals who received brokered case management, outpatient treatment, or services from an Open Access centre. On the other hand, a more recent study by Tsemberis et al. (2003) found that an Open Access centre that eliminated barriers to access to services was more successful than control programs in reducing homelessness, which included housing services. Therefore, the literature was inconclusive on which services provided the best avenues for accessing housing.

Table 4: Summary of articles exploring the theme of homelessness for Open Access centre clientele

Author	Target demographic	Country	Implication for housing status
Butler and Weatherley (1995)	Homeless middle-aged women	USA	It is suggested that definitions of homelessness are arbitrary, and a lack of adequate policies on income and housing perpetuates the problem.
Fitzpatrick-Lewis et al. (2011)	Homeless people with mental illness	Canada	For homeless people with mental illness, provision of housing upon hospital discharge was effective in improving sustained housing. For homeless people with substance abuse issues or concurrent disorders, provision of housing was associated with decreased substance use, relapses from periods of substance abstinence and health services utilisation, and increased housing tenure. Abstinent dependent housing was more effective in supporting housing status, substance abstinence, and improved psychiatric outcomes than non-abstinence dependent housing or no housing. Provision of housing also improved health outcomes among homeless populations with HIV.
Garrett et al. (2008)	Homeless youth	USA	The article explored choices to use illegal substances, issues of self-reliance, substance use, and relationships with street and housed persons were expressed as critical for both using services and transitioning to stable housing. Agency-related factors such as caring staff, a non-judgmental atmosphere, and flexible policies were perceived as important for service use.
Goering et al. (1990)	Single homeless women	Canada	An exploration of the problem of providing housing for single homeless women in hostels and Open Access centres. Four suggestions are offered that might help resolve this problem: (1) provide facilities for normal community living on a long-term or permanent basis; (2) develop

			permanent housing with flexible financial supports; (3) enlist consumer involvement in planning and governing the residences; and (4) ensure ongoing review of the quality and adequacy of both the housing and related services.
McBride et al. (1998)	People with severe mental illness	USA	This study aims to identify predictors of the duration of homeless spells. Those who received assertive community treatment exited homelessness sooner than individuals who received brokered case management, outpatient treatment or services from an Open Access centre. More assistance in finding and maintaining housing were especially predictive of shorter homeless spells. In general, people who received more services exited homelessness sooner.
Nelson et al. (2012)	Homeless	USA	This study examines the impact of a work-skills program grounded in an integrated services approach on both employment and related life domains. Results revealed improvement in all types of work and related life skills, employment and income, and related life skills were associated with improvement in self-esteem and self-efficacy. These improvements predicted stable housing situations at follow-up.
Pollio, Spitznagel, North, Thompson, and Foster (2000)	Housed and unhoused individuals	USA	Total service use of housed and unhoused individuals, exploring service usage of an Open Access centre, counselling and health services. For the Open Access centre, service use was highest immediately after clients obtained housing and would decrease in the months afterward, with the greatest decreases occurring immediately after housing was obtained.
Slesnick et al. (2008)	Homeless youth	USA	Youths who accessed substance abuse, mental health and case management services through an Open Access centre experienced significant improvements in mental health and housing stability, as well as reduced substance abuse.
Sosin, George, and Grossman (2012)	Homeless adults	USA	The relationship between the services clients receive in treatment programs and client ratings of program efficacy is explored. Ratings of program efficacy are positively predicted by program ambiance, the ambiance of referral arrangements, residence in programs providing housing and receipt of employment services. The measures of ambiance are predicted by receipt of professional services and help in locating housing. Receipt of advocacy services does not predict ratings of program efficacy nor ambiance; receipt of tangible services is negatively related to ratings of program efficacy. Results suggest that clients rate highly programs that have a positive ambiance or that provide services that clients view as immediately helpful for solving long-term needs.
Tsemberis, Moran, Shinn, Asmussen, and Shern (2003)	Homeless people with substance abuse issues	USA	Participants were randomly assigned to programs that emphasised consumer choice or to the usual continuum of care, in which housing and services are contingent on sobriety and progress in treatment. An Open Access centre that eliminated barriers to access to services was more successful than control programs in reducing homelessness.
Wenger et al. (2007)	Homeless people, individuals with mental illness, drug users, undocumented immigrants and sex workers	USA	The centre aims to advocate for housing/shelter and to enhance the physical, social, emotional, and economic health of clients. It has been extremely successful in providing comprehensive services.

Skills development

Only four articles discussed the benefits or challenges of skills development offered in Open Access centres. Where discussed, studies generally found it brought benefits to participants. However, few studies make the link between empowerment and skills development. This was a clear gap in the literature examining service provision and skills interventions. Often the types of skills being included had a focus on broader life or employment competences. For example, Nelson et al. (2012) examine the impact of a work-skills program grounded in an integrated services approach on both employment and related areas of life for homeless individuals. Their study found improvements in all types of work and related life skills, employment and income, and multiple other life realms from baseline to graduation and follow-up (Nelson et al., 2012). Hendry et al. (2011) discuss the trial of the incorporation of digital media in Open Access centres to enable access and for improving life skills. The paper presents the ways in which challenges were overcome, showing how technology facilitated the strengthening of relationships between the youth and the Open Access staff as well as creating life-enhancing experiences (Hendry et al., 2011). Martin and Nayowith (1988) examine the ways in which incorporating social group work skills in programs can create social support networks and community among mentally ill homeless people.

Table 5: Summary of articles exploring skills development interventions

Author	Intervention type	Target demographic	Country	Outcome
Hendry et al. (2011)	New technology (digital media curriculum) - life skills for information technology and digital media	Youth (13 to 25-year-olds)	USA	Life-affirming experiences of challenges overcome, which can help strengthen relationships between the youth and Open Access staff.
Martin et al. (1988)	Social group skills programs	Mentally ill homeless people	USA	The study examines if programs can create social support networks and community. The programs demonstrate support for indoor living and effective maintenance of homeless mentally ill people in the community.
McCay et al. (2015)	12-week Dialectical Behaviour Therapy (DBT) intervention	Street-involved youth	Canada	Overall results demonstrate that youth who received the DBT intervention demonstrated significant improvement in mental health challenges (e.g. depression, hopelessness and anxiety), as well as significant improvement in resilience, self-esteem and social connectedness immediately post-intervention. Participants in the wait-list control did not demonstrate significant improvement on any of the study outcome measures.
Nelson et al. (2012)	Work-skills program	Homeless youths	USA	Their study found improvements in all types of work and related life skills, employment and income, and multiple other life realms from baseline to graduation and follow-up.

Clients' experiences of Open Access centres

While only five articles wrote about client experiences of Open Access centres, they were found to be generally positively perceived by clients. Thompson et al. (2006) found that participants responded well to respectful, empathic and pet-friendly providers who were supportive and encouraging without disregarding their autonomy. Unsuitable and unsafe environments, as well as providers who were disrespectful, rigid, or had unrealistic expectations, put clients off using services. Another important factor affecting client retention included feeling 'cared for', as opposed to merely routine service provider encounters (Bieterman et al. 2013). In addition, program ambiance as well as the success and efficacy of the programs themselves (Sosin et al. 2012) were deemed important. Sosin et al. explored the relationship between the services clients receive in treatment programs and client ratings of program efficacy. Their study found that clients rate highly programs that have a positive atmosphere/environment or that provide services that clients view as immediately helpful for solving long-term needs. This highlights the importance of Open Access centres creating more than simply effective programs and services.

Morse et al. presents a comparison of a daytime Open Access centre, a mental health clinic and a continuous treatment team program. The study found that clients in all three treatment programs spent fewer days per month homeless, showed fewer psychiatric symptoms and had increased income, interpersonal adjustment and self-esteem. Meanwhile, clients in the continuous treatment program had more contact with their treatment program, were more satisfied with their program, spent fewer days homeless and used more community services and resources than clients in the other two programs.

Table 6: Summary of articles exploring client experiences of Open Access centres

Author	Evaluation type	Target demographic	Country	Outcome
Biederman et al. (2013)	Interactions with service providers and the degree to which these interactions are perceived as social support	Homeless women	USA	The study revealed being 'cared for' was experienced within service provider encounters. Participants expressed expanded definitions of service providers and made clear distinctions between routine support expected from a provider and received social support, or being 'cared for' by providers.
Morse et al. (1992)	The effectiveness of three community-based treatment programs: traditional outpatient treatment offered by a mental health clinic, a daytime Open Access centre and a continuous treatment team program that included assertive outreach	Homeless mentally ill people	USA	A longitudinal experimental design was used to compare a high staff-to-client ratio, and intensive case management. At 12-month follow-up, clients in all three treatment programs spent fewer days per month homeless, showed fewer psychiatric symptoms, and had increased income, interpersonal adjustment, and self-esteem. Clients in the continuous treatment program had more contact with their treatment program, were more satisfied with their program, spent fewer days homeless and used more community services and resources than clients in the other two programs.

Sosin et al. (2012)	Treatment programs	Homeless adults	USA	The relationship between the services clients receive in treatment programs and client ratings of program efficacy is explored. Ratings of program efficacy are positively predicted by program ambiance, the ambiance of referral arrangements, residence in programs providing housing, and receipt of employment services. The measures of ambiance are predicted by receipt of professional services and help in locating housing. Receipt of advocacy services does not predict ratings of program efficacy nor ambiance; receipt of tangible services is negatively related to ratings of program efficacy. Results suggest that clients rate highly programs that have a positive ambiance or that provide services that they view as immediately helpful for meeting long-term needs.
Thompson et al. (2006)	Service utilisation	Homeless young adults	USA	Focus groups were conducted with 60 participants recruited from an Open Access centre for young adults who are homeless. Qualitative analyses found participants responded favourably to respectful, empathic, and pet-friendly providers who were supportive and encouraging without disregarding their autonomy. Barriers to utilisation included unsuitable and unsafe environments, and providers who were disrespectful, rigid, or had unrealistic expectations. Providers can assist youth and young adults to move into developmentally-appropriate, stable living situations which will likely prevent them from becoming part of the adult homeless population.
Tsemberis et al. (2003)	Consumer choice in care	Homeless people experiencing mental illness and substance abuse issues	USA	Participants were randomly assigned to programs that emphasised consumer choice or to the usual continuum of care, in which housing and services are contingent on sobriety and progress in treatment. An Open Access centre that eliminated barriers to access to services was more successful than control programs in reducing homelessness.

Challenges

Funding

According to Johnsen et al. (2005), the vast majority of Open Access centres in the UK are provided by non-statutory/not-for-profit or charitable organisations. A common theme in the literature, although seldom written about in depth, is the highly precarious nature of funding and its vulnerability to policy changes (Johnsen et al., 2005; Meagher, 2008; N. Slesnick et al., 2007; Wenger et al., 2007). As Slesnick et al. (2007) discuss, funding for homeless service agencies is sometimes dependent upon the use of evidence-based practices. Thus, this gap is an important one to fill in terms of the literature. As Johnsen points out, unless all staff volunteer their time and the site is donated, funding will be needed for hiring staff, paying for the rent and utilities of the building,

having food available and for the purchase of other services, including bus passes (Johnsen et al., 2005). Funding sources frequently include private donors, charitable foundations and local, state or federal governments (Johnsen et al., 2005). New Open Access centres particularly struggle to keep afloat financially as funding for a new centre may reduce available funding for ongoing service agencies, exacerbating existing struggles to maintain minimum funding requirements (Johnsen et al., 2005). According to Johnsen et al. (2005), the ideal situation is to foster a collaborative atmosphere among Open Access centres so they are not in competition with each other for dwindling local funds.

Table 7: Summary of articles exploring client experiences of Open Access centres

Author	Study	Country	Outcome for funding
Esparza (2009)	The extent to which the supply of funds, the need for services, and politics affect the prevalence of services	USA	The findings suggest that political culture and supply measures (e.g., federal grants and homeless youth funding) have a greater effect on the prevalence of programs than the need for services.
Johnsen et al. (2005)	Drawing upon a national survey of service providers and a series of interviews and participant observations with Open Access centre staff and users, the paper argues that Open Access centres act as important sources of material resource and refuge for homeless people	UK	The ideal situation is to foster a collaborative atmosphere among Open Access centres so they are not in competition with each other for dwindling local funds.
Slesnick et al. (2008)	Therapy and case management for homeless youth	USA	While treatment offered through Open Access centres for homeless youth can positively impact homeless youth, policy, funding, and service provision need greater focus, collaboration, and support if youth homelessness is to be successfully addressed.
Wenger et al. (2007)	Description of a community-based coalition of representatives from community-based organisations in San Francisco and their attempts to establish a model for an Open Access centre	USA	Although the centre struggles financially, it has been extremely successful in providing comprehensive services to the homeless population, and community collaboration has helped meet the outlined goals.

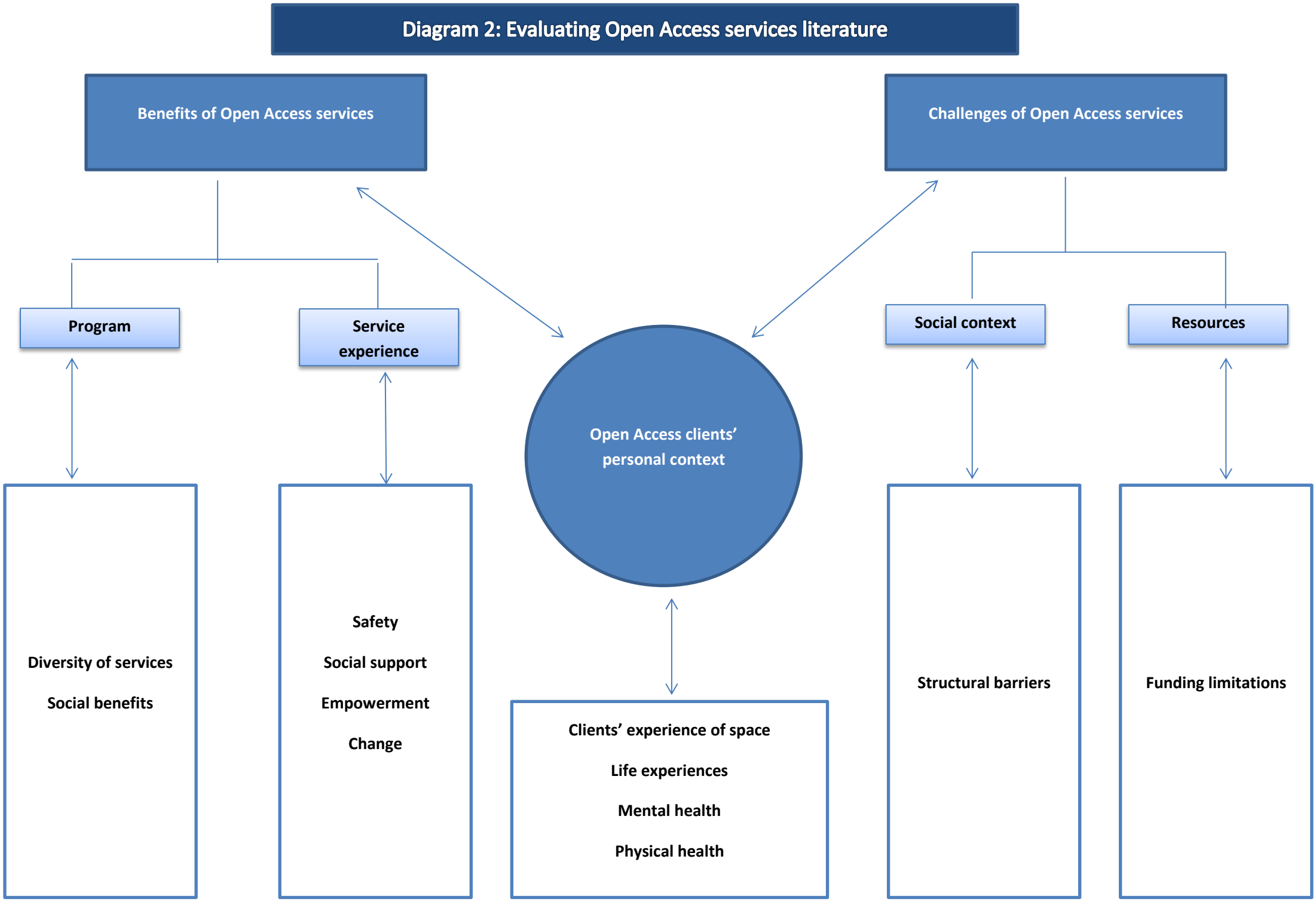


Diagram 2: Evaluating Open Access services literature
Benefits of Open Access services
Challenges of Open Access services
Program
Service experience
Social context
Resources
Open Access clients' personal context
Diversity of services
Social benefits
Safety
Social support
Empowerment
Change
Clients' experience of space
Life experiences
Mental health
Physical health
Structural barriers
Funding limitations

Diagram 2 is further developed and modified from Magee and Huriaux's (2008) study that looks at an evaluation of a Ladies' Night program for homeless and marginally housed women in San Francisco. The diagram illustrates the benefits and challenges of Open Access centres, showing how the personal context of each client is also entangled in their experience of the centres. The bidirectional arrows indicate that there is a two-way process of influence and that while Open Access centres have both benefits and challenges, extraneous factors affect and are affected by the wider context.

Conclusion

Open Access centres provide important services to homeless and marginalised individuals. They attempt to mitigate and insulate many of the daily challenges of homelessness and poverty in a physically, socially and emotionally safe place. In addition, they have the potential to facilitate the engagement of homeless people into treatment and back into the mainstream, as evidenced through several studies presenting successful interventions, particularly in the healthcare space. Individuals utilising Open Access centres experienced several benefits, including service provision, health interventions, housing assistance and access to skills development programs. Most outcomes experienced by clients attending Open Access centres were favourable, with improvements to their daily lives being reported in many studies. The major challenge to the work of Open Access centres was the issue of funding.

Since Open Access centres act as gateways to other services and offer intervention potential for these marginalised sectors of the community, understanding service utilisation and conducting formal evaluation in order to ascertain the impact of the treatment services in Open Access centres is of utmost importance (De Rosa et al., 1999). De Rosa et al. (1999) show that the literature determining the efficacy of these programs for serving people experiencing homelessness is, for the large part, bereft of such analysis. Slesnick et al. (2008) reiterate the importance of treatment offered through Open Access centres for people experiencing homelessness (youth specifically), showing how it can positively impact homeless policy, funding, and service provision. Thus, greater policy and academic focus, collaboration and support is required in order to tackle the complex issue of homelessness (Slesnick, Kang, Bonomi, and Prestopnik, 2008). To date, few studies examine the impact of overall services on their clientele. The literature tends to focus on a specific demographic attending a Open Access centre and how a specific service or set of services facilitates improvements in designated outcomes; for example, the success of HIV prevention interventions on homeless youth (Tucker et al., 2012). The impact of targeted interventions on homeless subgroups such as youth, women, immigrants, indigenous or other ethnic minorities as well those experiencing mental health issues dominates evaluative efforts in the literature. In addition, nearly all studies were from the US context, with a few articles from Canada and the UK. Therefore, this study attempts to fill the gap in the Australian context evaluating the full range of services for all attendees, without any restricting identity parameters who generally attend four Open Access centres.

Research Methods

Quantitative Survey

Survey design

The quantitative survey was designed to assess the demographics of Open Access centre users, their service needs and engagement with services, and the perceived effects of centre usage. Where appropriate, the survey adopted or adapted questions used previously by participating agencies for internal research, to enable comparison over time. The final survey instrument was developed through an iterative process involving the project's Steering Group and the researchers, and informed by the qualitative interviews conducted for this project. The survey instrument is included in Attachment 2.

Sampling

For all centres except Prahran Mission's Engagement Hub, the survey's sampling frame was open to include any person who attended the centres during the data-gathering period, in keeping with their open-door policies. It was anticipated that conducting multiple survey sessions over several weeks at each site would ensure that the samples captured would reflect the centres' client populations as a whole. Centre clients were notified by poster, and orally when survey sessions were in progress. Interested clients were asked to make themselves known at the reception desk, or with centre staff, or directly with the interviewers. Interviewers also actively recruited participants if there were no volunteers waiting. Informed consent was obtained prior to interview.

At the Prahran Mission site the sampling frame was restricted to registered clients and a small number of unregistered regular users. The reason for this stems from the fact the Engagement Hub is a small venue that focuses its services towards psychosocial support for people experiencing disadvantage and mental health service needs. There was concern that due to its location on a busy St Kilda intersection, an unrestricted sample would be weighted heavily with non-centre users who had heard about the $20 payment. Interview sessions were conducted at the Engagement Hub until the entire list of registered clients currently attending the venue was exhausted.

The initial intended sample size was 100 people at each of the four centres. At the request of Sacred Heart Mission their sample was expanded to 200, to include a quota of 40 participants at the Women's House to ensure sufficient representation for that service.

A total of 44 survey sessions were conducted over a five-week period between 15th March and 22nd April 2016, with 496 clients completing the survey. Survey participants were paid $20 in the form of shopping vouchers.

Table 8: Number of survey sessions and respondents per site

Agency	*Centre*	*Number of survey sessions*	*Number of survey respondents*
Prahran Mission (PM)	Engagement Hub 101 Carlisle	8	95
Sacred Heart Mission (SHM)	Central	10	161
	Women's House	5	40

St Mary's House of Welcome (SMHOW)	St Mary's House of Welcome	10	100
VincentCare Victoria (OCC)	Ozanam Community Centre	11	100
	Total	44	496

Data collection

Peer Education Support Program (PESP) workers (with lived experiences of homelessness) employed through the Council to Homeless Persons (CHP) conducted the interviews, which were delivered verbally with responses recorded online in Survey Monkey using iPads. The PESP workers received training in interviewing from CHP and attended further training at The University of Melbourne on conducting the Open Access Survey (OAS). PESP workers were employed to conduct the OAS because it has been the experience of the centres that clients engage better with research activities when they are delivered by peer workers.

Survey implementation was supervised and facilitated by University of Melbourne researchers in conjunction with Sacred Heart Mission and the Council to Homeless Persons.

Qualitative Interviews

University of Melbourne researchers conducted qualitative interviews with 41 clients, interviewing 26 men and 15 women. Ten interviews per site were conducted, with one couple being interviewed simultaneously at St Kilda 101. Interviews were carried out in order to better understand the role of Open Access centres in the context of people's life histories and circumstances.

In order to maximise the inclusion of information-rich cases in the qualitative sample, purposive sampling was adopted to recruit a cross-section of genders, ages, levels of need and service engagement. Centre staff assisted the researchers in the selection of interviewees through their knowledge of clients.

Informed consent was obtained prior to interview. Clients were interviewed individually for up to one hour each, and paid $20 in the form of shopping vouchers. The interviews were audio-recorded with participants' permission, and subsequently transcribed for thematic analysis.

The interviews were semi-structured to cover a prepared schedule of topics addressing why and how people use the Open Access services, their experiences using the services including benefits and unintended consequences, and future directions for the services. The interviewers expanded topics and followed new themes as the opportunities arose within and between interviews. Key themes were identified and included in subsequent interviews and research phases.

Observation

People experiencing significant disadvantage, especially homelessness, have reduced opportunities for social interaction and acceptance. This component of the research is intended to capture information about how the centres function as venues for clients to experience social engagement and social inclusion, both as a consequence of using services or facilities, and as a benefit sought for its own sake.

Researchers spent four hours observing at each site with the exception of Prahran Mission's Engagement Hub and Sacred Heart Mission's Women's House, as the facilities at these locations were deemed inappropriate for this methodology. In these sessions, individual clients were not the focus of observation. Instead researchers noted how clients as a whole utilised spaces within the centres, how clients interacted with each other and with staff at the group level, and how the facilities on offer – including the built environment – may influence social interaction.

Research Findings

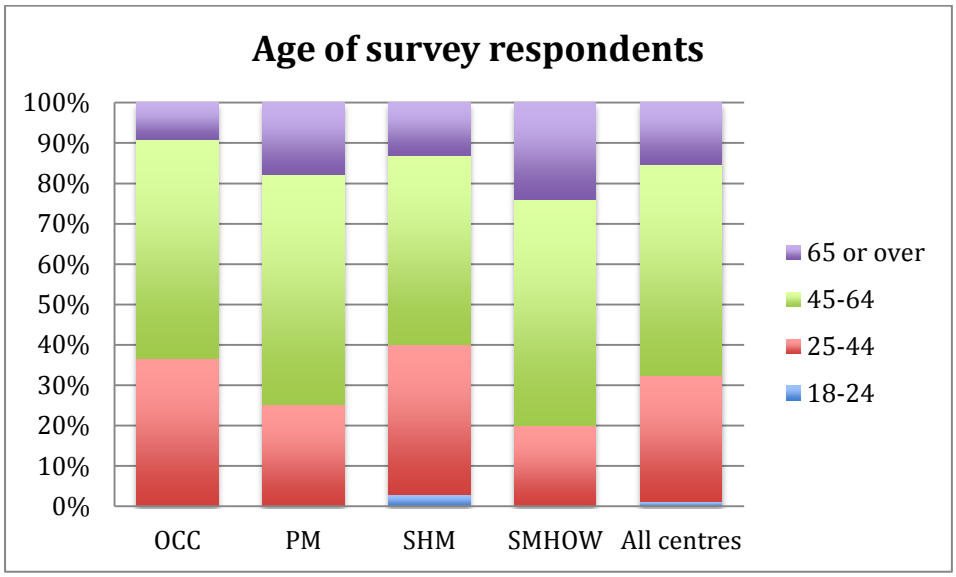
Who Uses Open Access Centres?

This section draws on survey data from 496 clients to describe the aggregate characteristics of Open Access centre users. Data tables corresponding to the charts are provided in the appendices.

Basic demographics, income, housing and homelessness

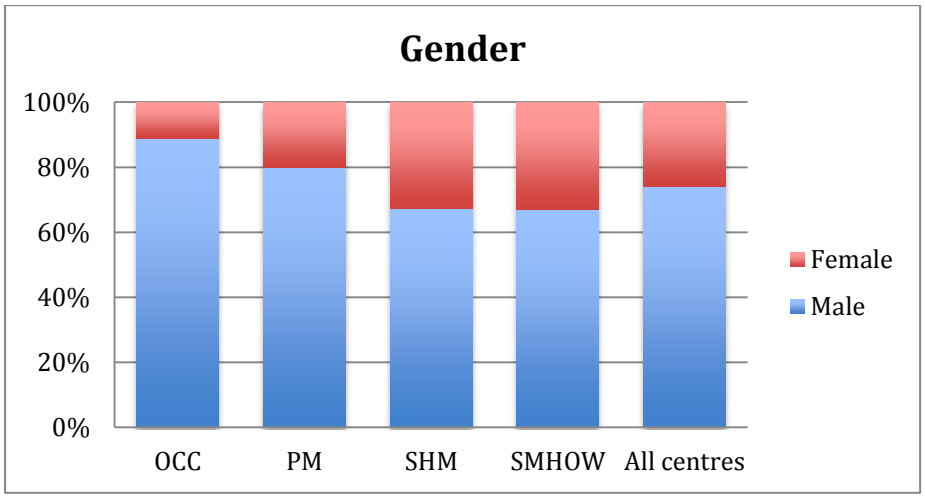
The majority (68%) of clients surveyed are older than 44 years. Very few people under 25 attend the centres.

Figure 1: Age of survey respondents



The client population across all centres is overwhelmingly male, which is reflected in the 74% male survey sample. The gender balance does however vary a little between centres, as Figure 2 shows. One respondent recorded their gender as Other – Transgender.

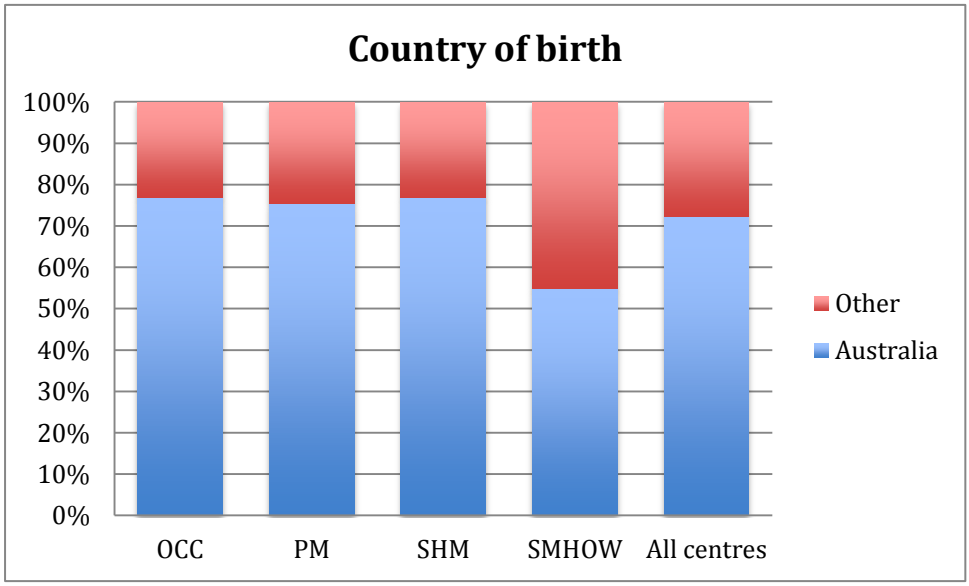
Figure 2: Gender



It should be noted that Sacred Heart Mission's Women's House was reserved a quota of 40 respondents to ensure sufficient representation of women and women-only services at their centre.

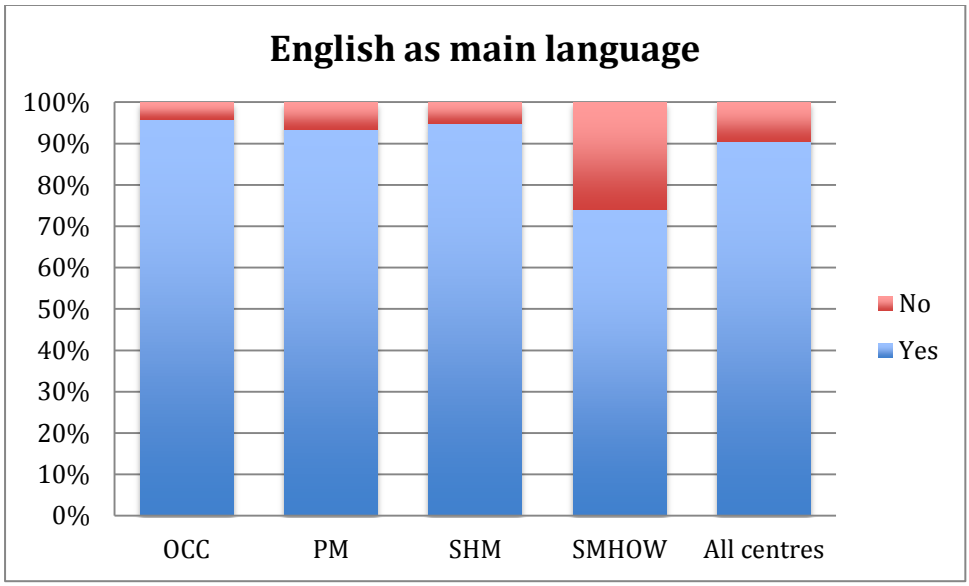
Most of the survey sample (72%) were born in Australia. Again the proportion varied across centres, with St Mary's House of Welcome recording a much higher proportion of overseas-born, primarily from China or Vietnam. The predominant countries of birth outside of Australia for the other centres were New Zealand and the United Kingdom.

Figure 3: Country of birth



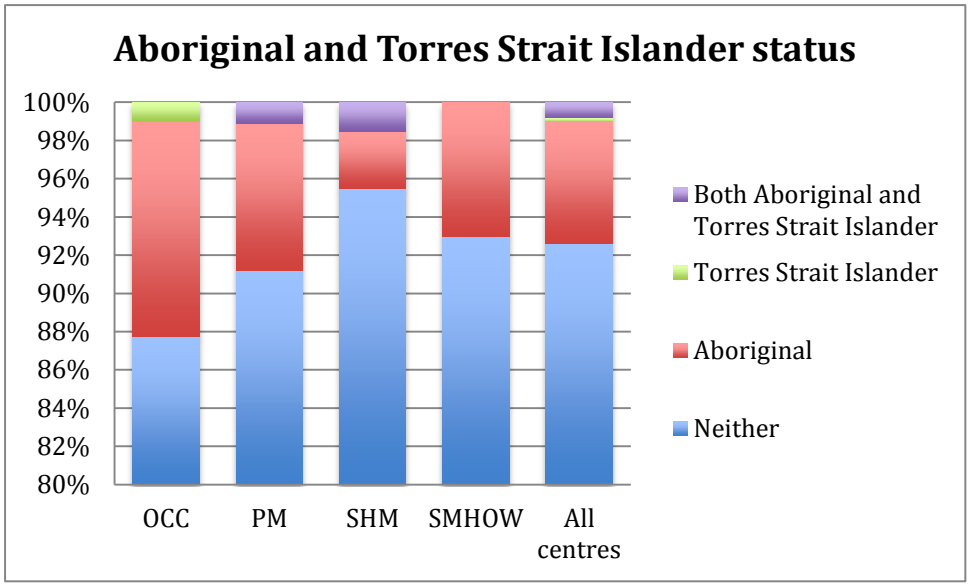
English is spoken by 90% of survey respondents. The most common other main languages are Mandarin and Vietnamese, again at St Mary's.

Figure 4: Main language spoken



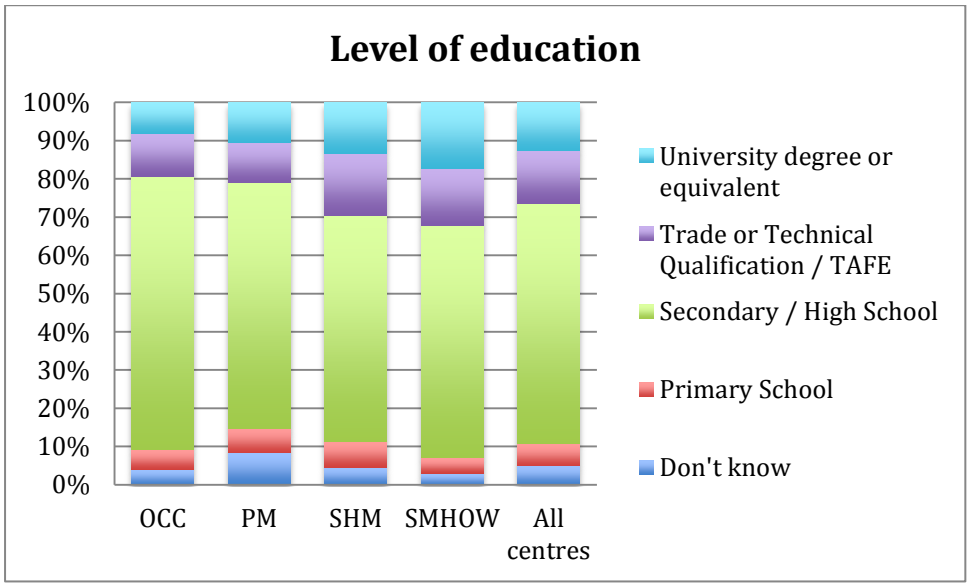
About 8% of the sample identified as Aboriginal and/or Torres Strait Islander, with Ozanam Community Centre recording a higher proportion than other centres.

Figure 5: Aboriginal and/or Torres Strait Islander status



The educational status of the survey sample is similar across the centres, with 26% of respondents holding a tertiary qualification. While this is well below the national rate of 38% for people aged between 25 and 64, it is near the national rate of 30% for those aged between 55 and 64[1].

Figure 6: Educational status

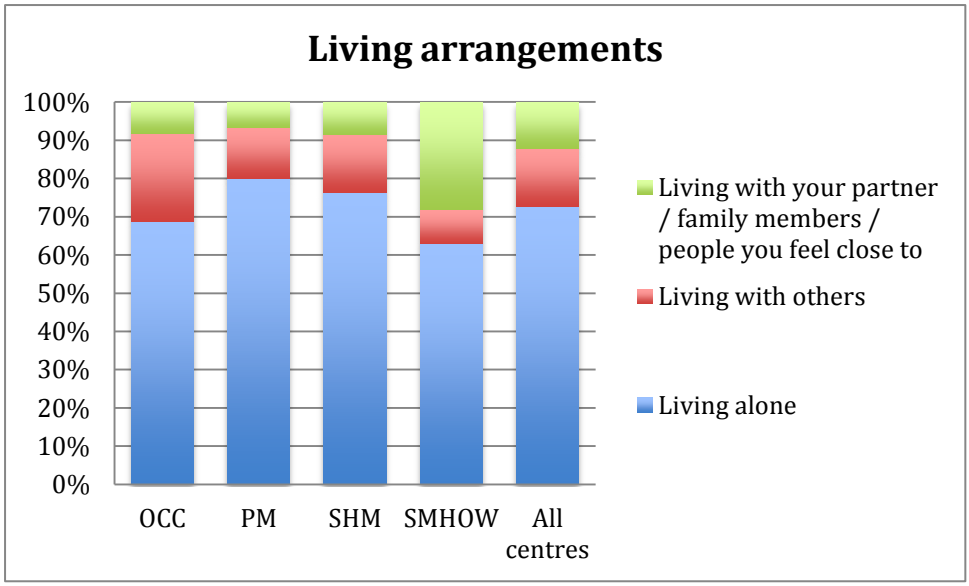


This would suggest that the education levels of centre clients are close to the general population when accounting for age.

[1] Source: OECD. Education at a glance: OECD indicators 2012 Australia
www.oecd.org/edu/eag2012 http://dx.doi.org/10.1787/eag-2012-en

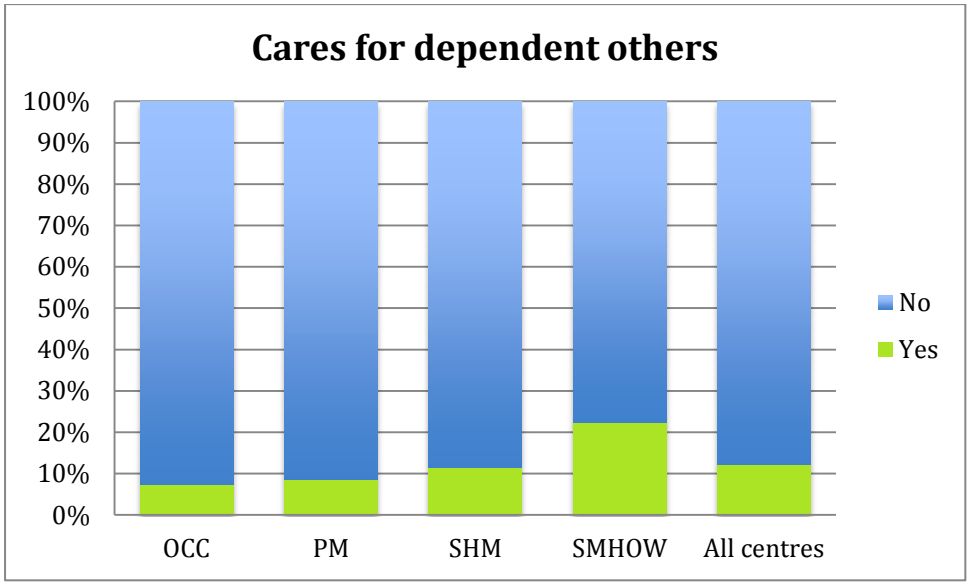
The majority (73%) of centre clients live alone. This is well beyond national census figures of 8% of people aged between 15 and 64, and 25% of people 65 and over[2].

Figure 7: Living arrangements



Fifty-eight survey respondents (12% of the sample) provide care for a total of 60 children and 35 adults.

Figure 8: Providing care for dependent others

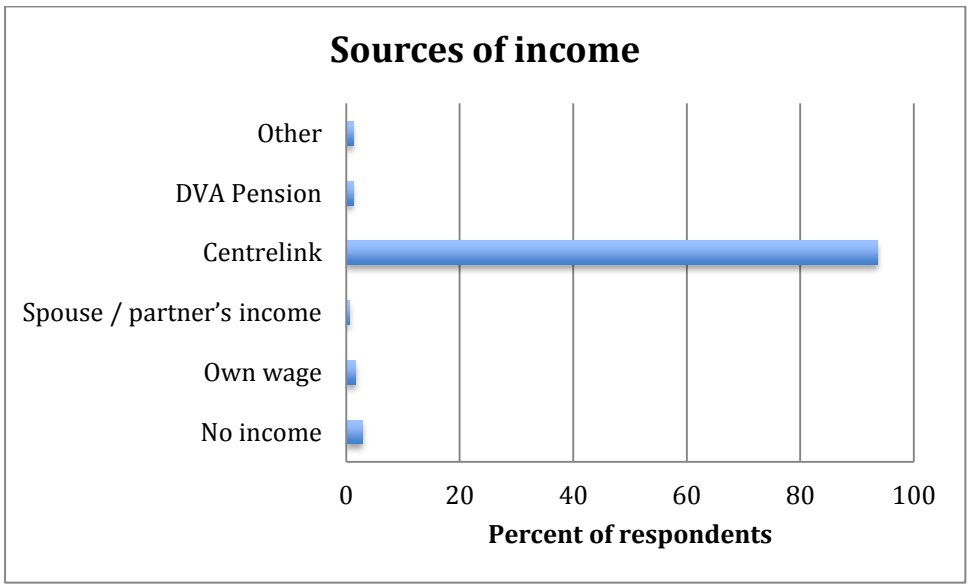


[2] Source: Australian Bureau of Statistics. 3236.0 - Household and Family Projections, Australia, 2011 to 2036

Income

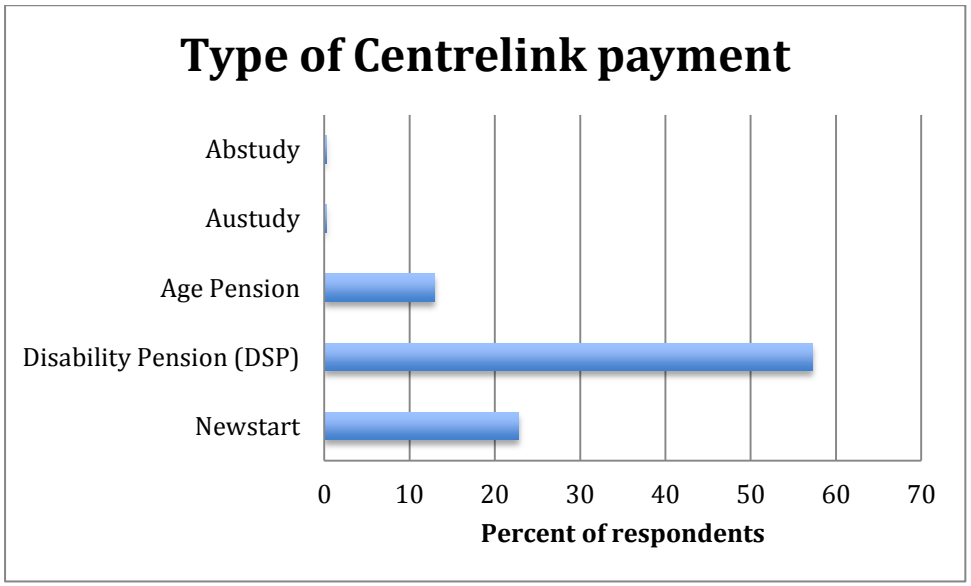
Centrelink is the most common source of income for the centres' clients, with 94% of the sample in receipt of payments.

Figure 9: Sources of income



57% of the sample receive a Disability Pension, 23% are on Newstart and 13% the age pension.

Figure 10: Centrelink payments



Around 61% of clients aged under 65 years and 22% of clients aged 65 years or older were on Disability Pensions. Figure 11 shows that among people aged under 65 years with and without Disability Pensions, the key difference between the two groups was that people without Disability Pensions were more likely to report no illness, and people with Disability Pensions were more likely to report physical and mental health issues. There were similar percentages of people with either a

physical or mental illness. Overall of people aged under 65 years, 49% of those without a Disability Pension and 69% of those with a Disability Pension were experiencing a mental illness.

Figure 11: Illness by Disability Pension (DSP)

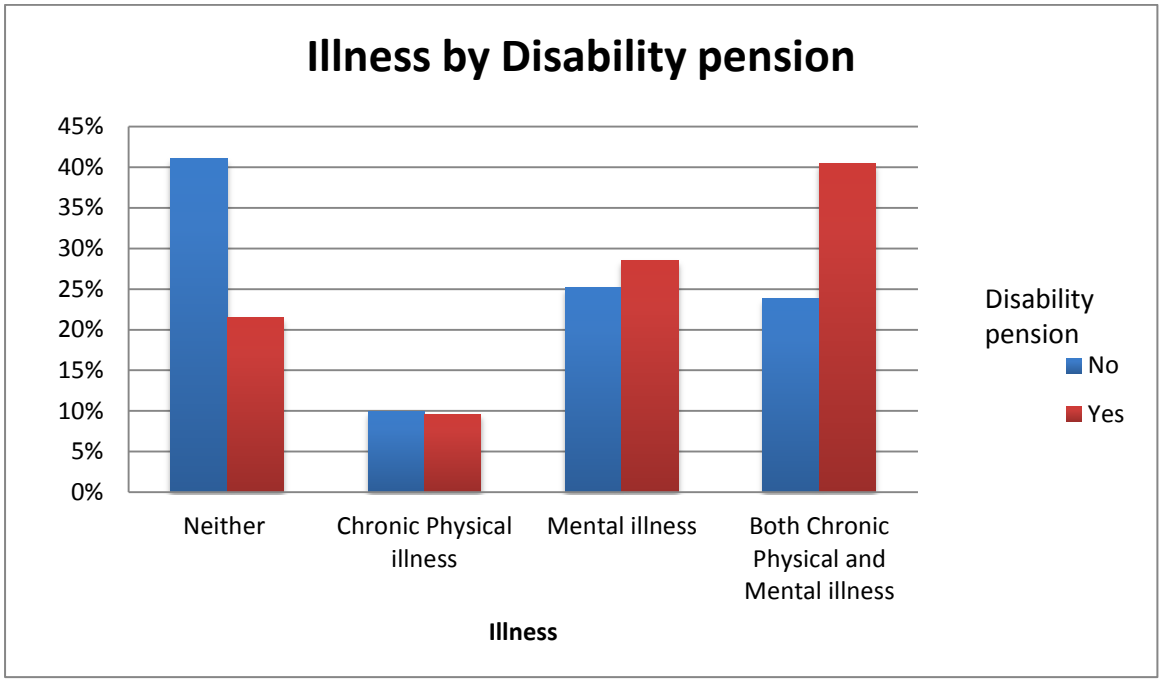
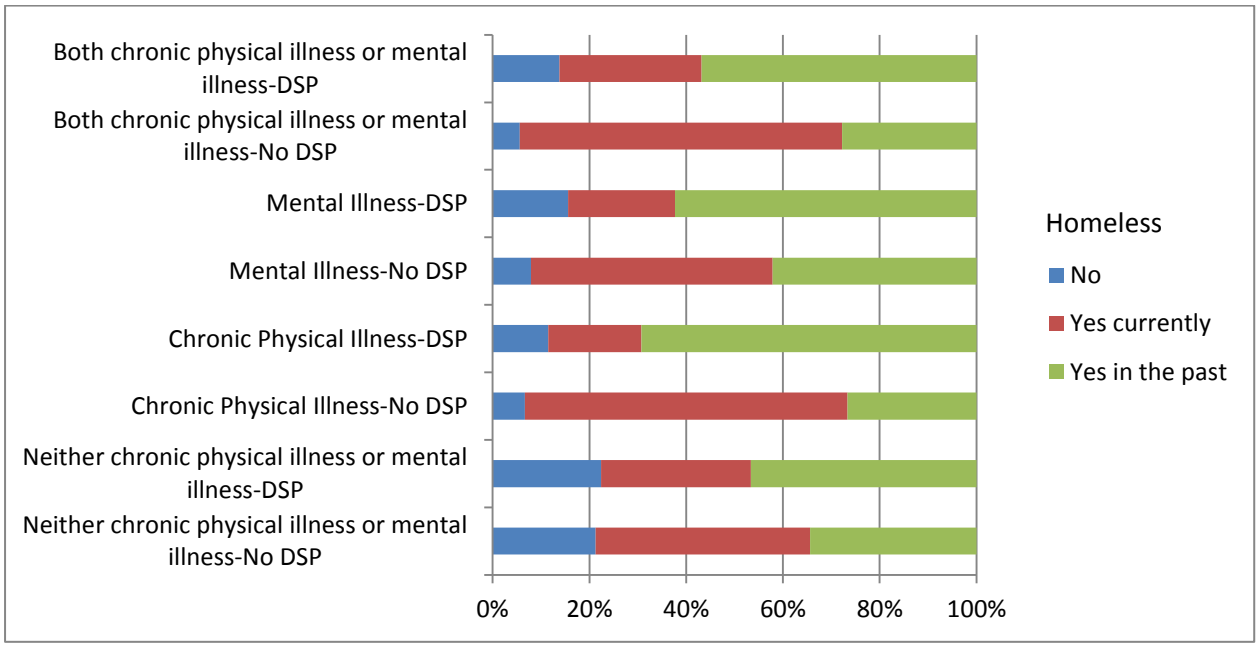


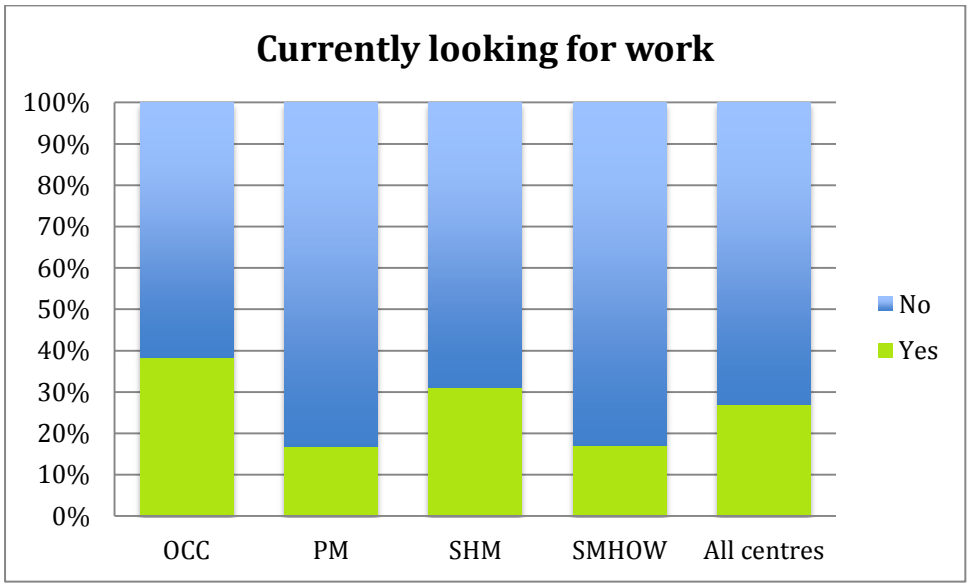
Figure 12 shows that among people aged under 65 years, those with Disability Pensions were less likely to be currently homeless. This was particularly marked for people with mental illness, chronic physical illness or both. This suggests Disability Pensions may play a role in stabilising housing for client populations of Open Access services. It also indicates that there may be eligible clients who are currently not receiving benefits to which they are entitled.

Figure 12: Illness by Disability Pension (DSP) by homelessness



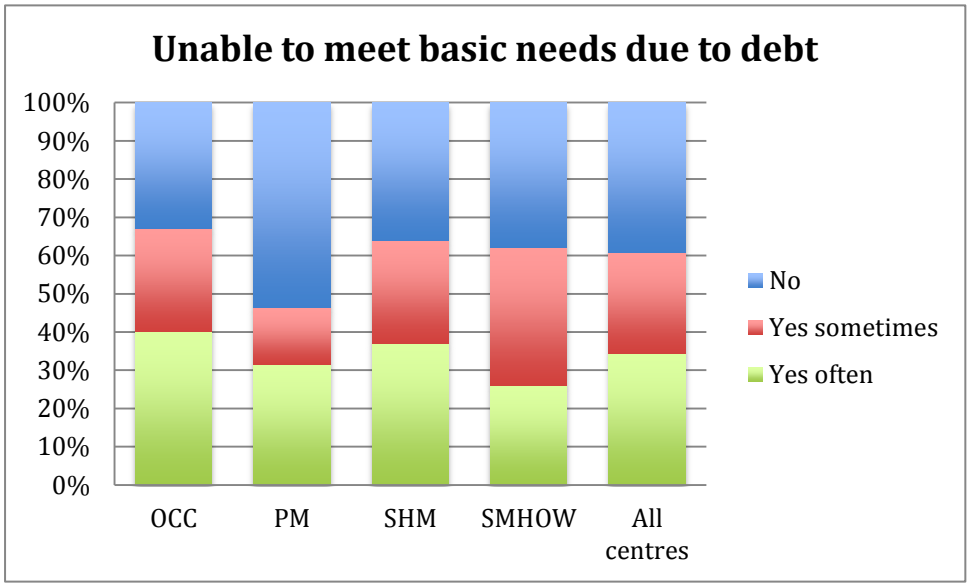
27% of the sample were looking for work at the time of the survey. This rate was higher at two centres – OCC and SHM – and lower at PM and SMHOW, which have more people on Disability Pensions.

Figure 13: Looking for work



Most respondents (61%) had been unable to pay for basic needs on one or more occasions in the past six months due to debt.

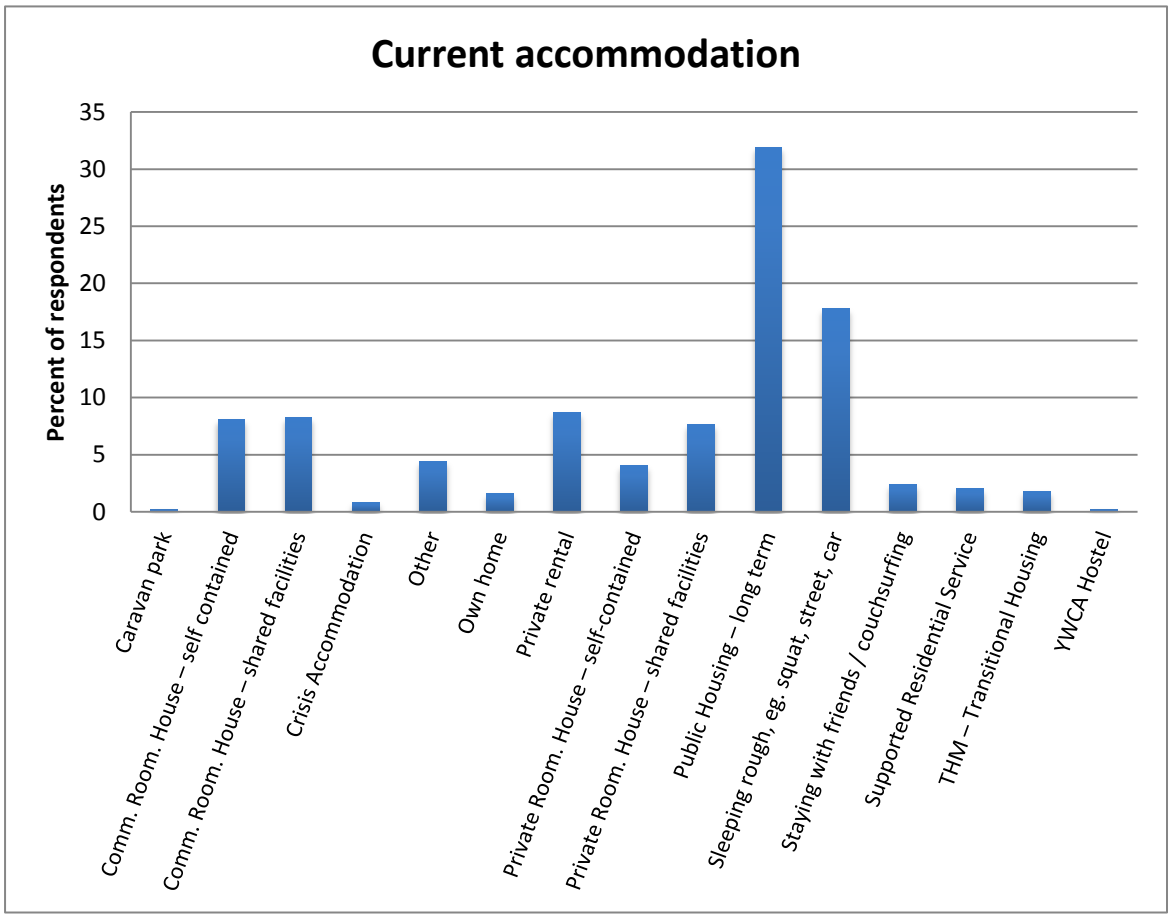
Figure 14: Affected by debt



Housing

A third of the client sample live in public housing, another third live in rooming houses – either community-run or private – and almost a fifth are sleeping rough.

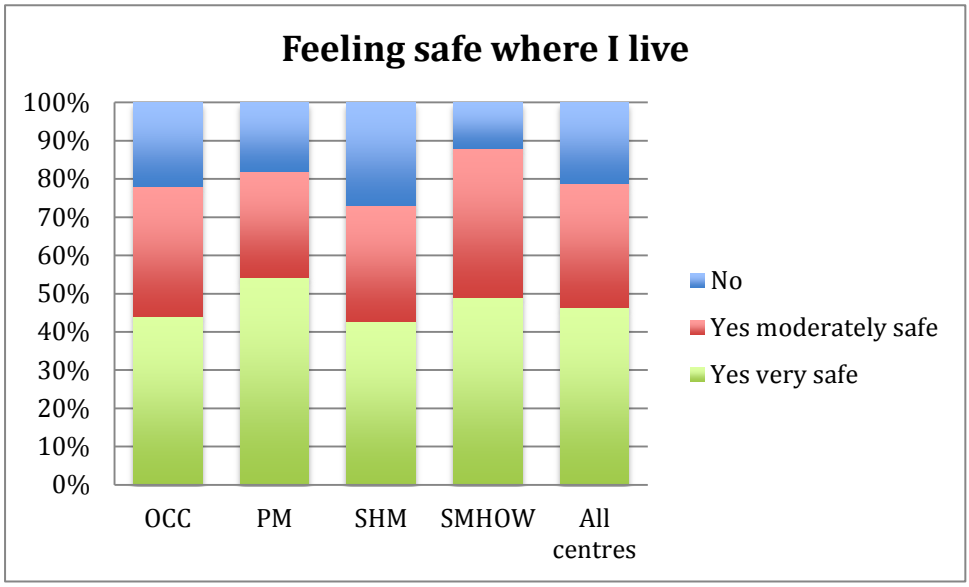
Figure 15: Current accommodation



The variation between centres in clients' accommodation is considerable: 56% of the SMHOW sample live in public housing and 9% sleep rough, whereas 25% of the OCC sample sleep rough and 31% live in public housing. For detailed information on client accommodation for each centre, see appendices.

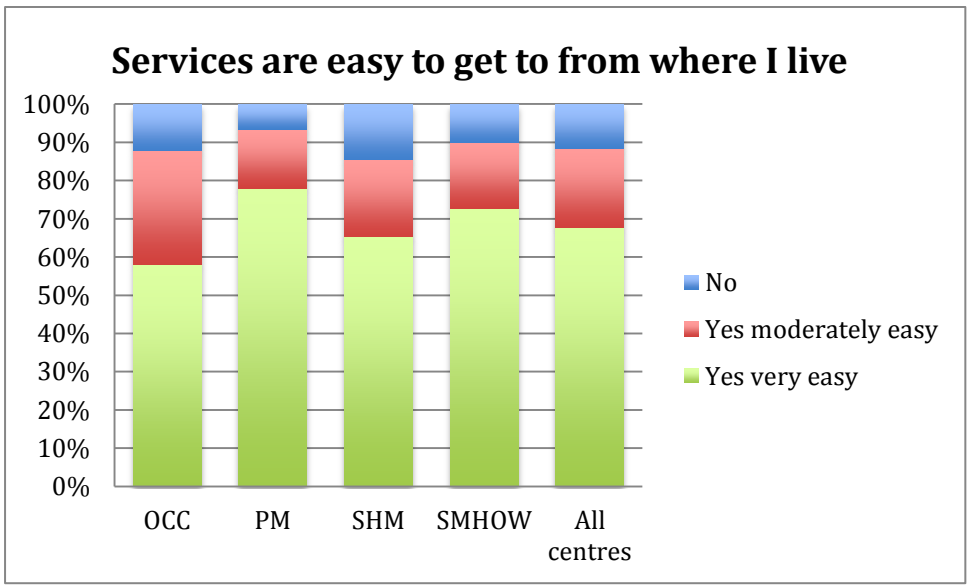
One in five clients do not feel safe where they live. This figure is higher for SHM, where more clients live in rooming houses.

Figure 16: Feeling safe



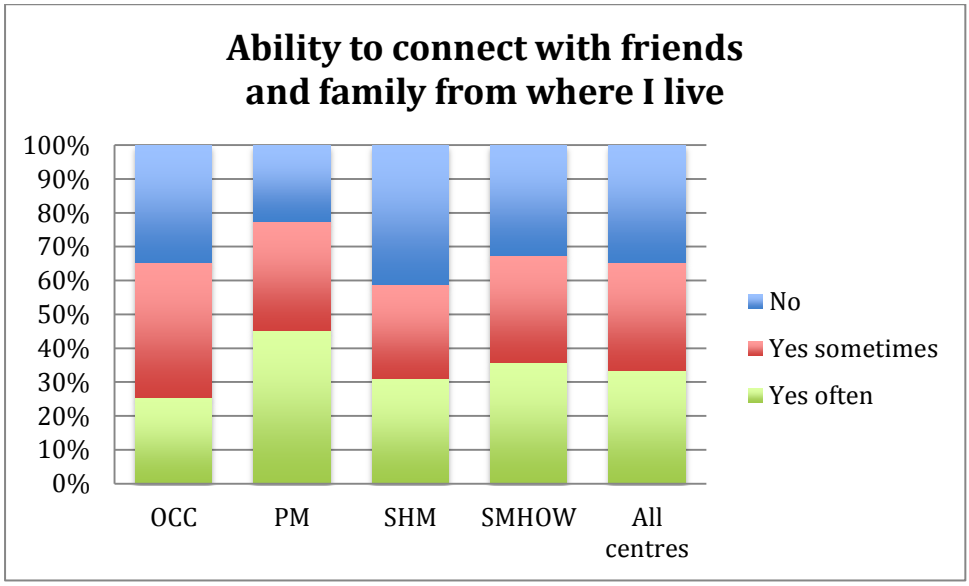
Most of the sample report that services and facilities are easy to reach from where they live. People attending the centres serviced by more tram routes – PM and SMHOW – give the highest ratings.

Figure 17: Ease of getting to services and facilities



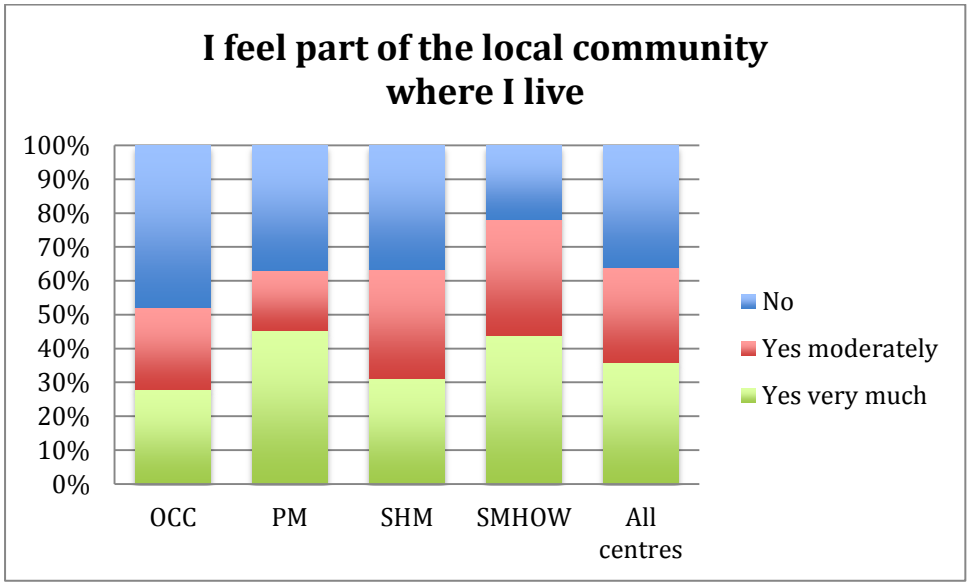
More than a third of the sample (35%) reports difficulty connecting with friends or family from where respondents live. The marked difference between the two St Kilda-based centres – SHM and PM – may be accounted for by the differences in client accommodation, with SHM having double the proportion of clients living in rooming houses and four times as many sleeping rough.

Figure 18: Ability to connect with friends and family



About the same proportion of the sample (36%) does not feel part of the local community where they live. On this dimension PM and SHM clients are similar, at 35% and 37% respectively.

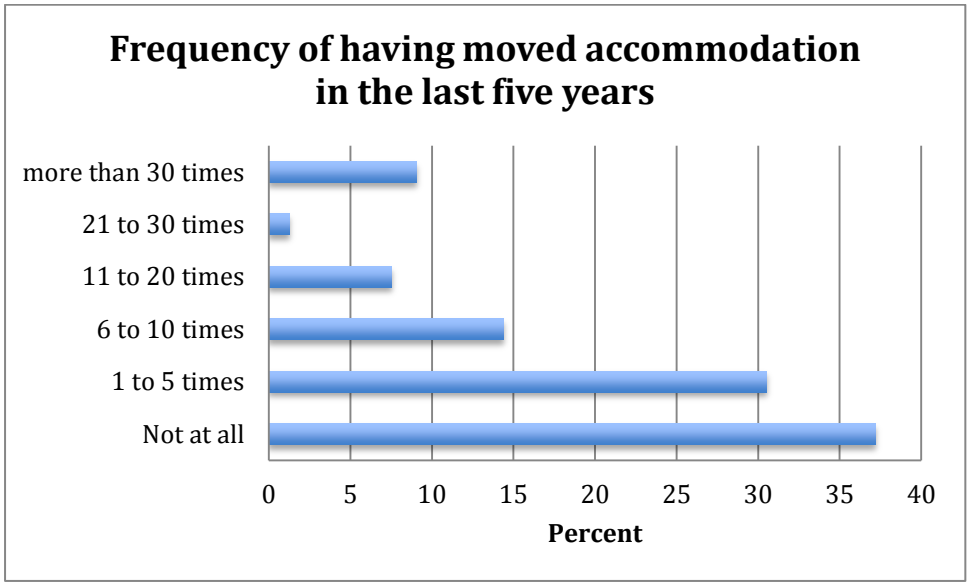
Figure 19: Feeling part of local community



OCC clients feel the most isolated (48%), and SMHOW clients the least (22%). These differences may be related to the catchments of the centres. Many OCC clients come from suburbs distant from the centre, whereas many SMHOW clients come from public housing across the road. This would suggest that SMHOW itself helps to create a feeling of local community for residents.

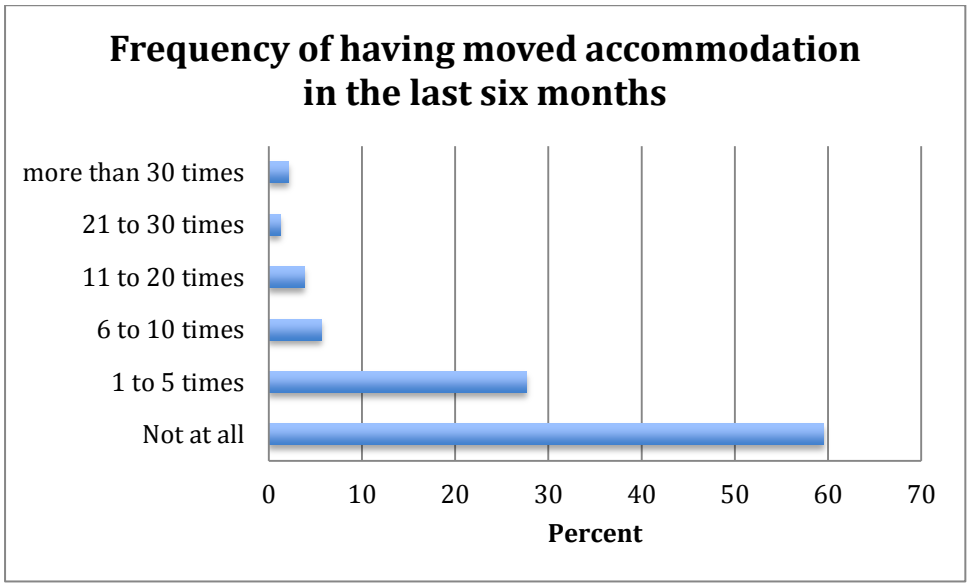
Lack of appropriate housing and unstable accommodation are common experiences for centre clients, with 32% of the sample having moved more than five times in the previous five years.

Figure 20: Frequency of moving accommodation in last five years



Meanwhile, 40% of the sample had moved at least once within the six months prior to interview:

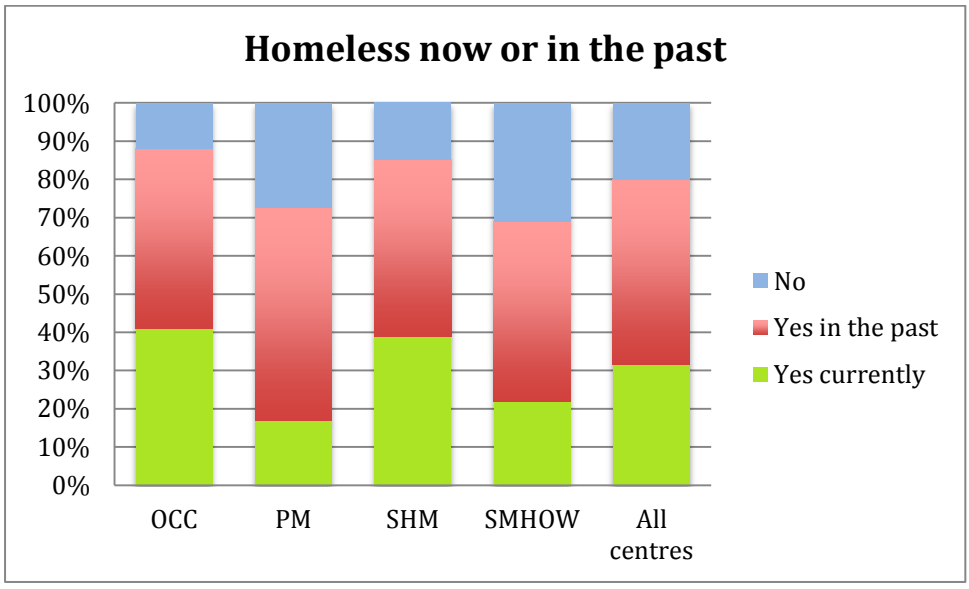
Figure 21: Frequency of moving accommodation in last six months



There are marked differences between centres due to the relative proportions of clients who have public housing or are experiencing homelessness. SMHOW and PM clients show lower accommodation turnover than OCC and SHM clients.

Across the whole sample, 32% were experiencing homelessness at the time of survey. OCC and SHM were highest at 41% and 39% respectively, compared with 22% at SMHOW and 17% at PM.

Figure 22: Current and past homelessness



Nevertheless, 80% of the entire sample have experienced homelessness, with 48% having been homeless in the past. Only 12% of OCC clients have never been homeless, and even within the most stably housed group at SMHOW, just 31% have never been homeless.

While the relative proportions of experience of homelessness vary by centre, the proportions vary little by gender. The table below shows that across the four centres, around 20% of male and female clients have never been homeless, a little over 30% are currently homeless, and just under 50% have been homeless in the past.

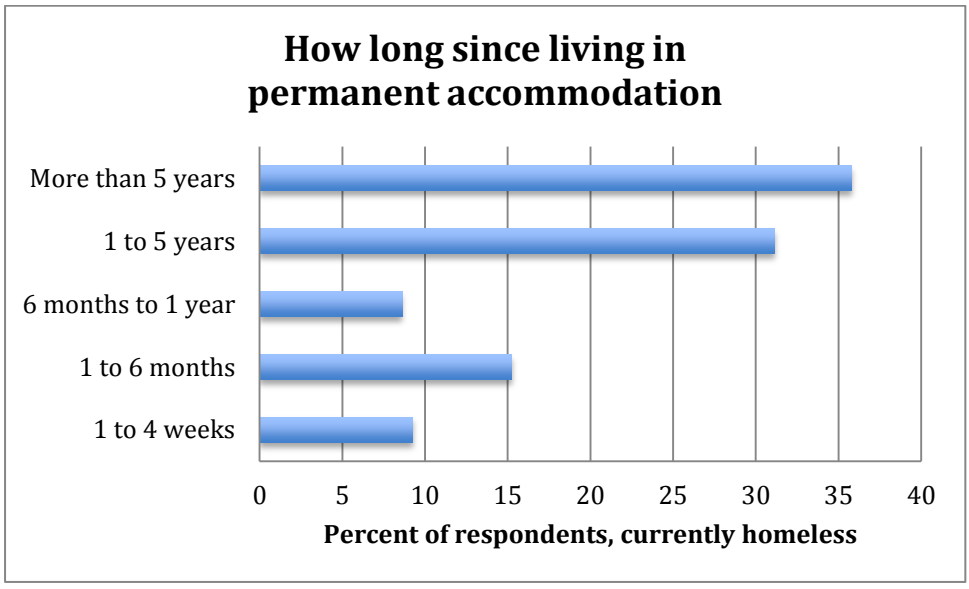
Table 9: Experience of homelessness by gender

Gender	Ever been homeless		
	No	*Yes currently*	*Yes in the past*
Female n=128	18.8%	33.6%	47.7%
Male n=364	20.3%	31.0%	48.6%

Note: one client who has been homeless in the past identified as transgender

Participants who reported being currently homeless were asked how long it was since they had lived in permanent accommodation, which was described as for more than two years. Over one third (36%) had been homeless for five years or more. Another 31% had been homeless for one to five years.

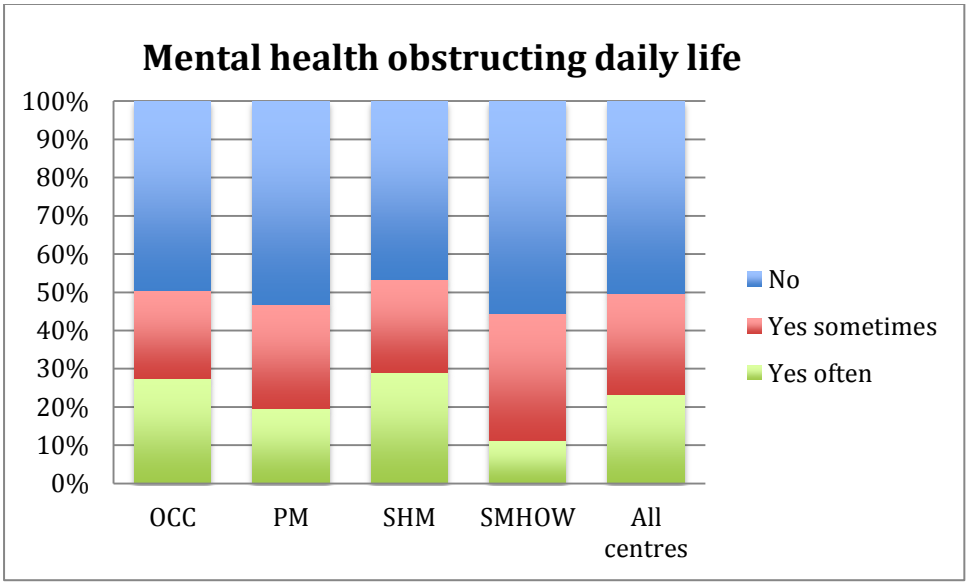
Figure 23: How long since living in permanent accommodation



Health and well-being

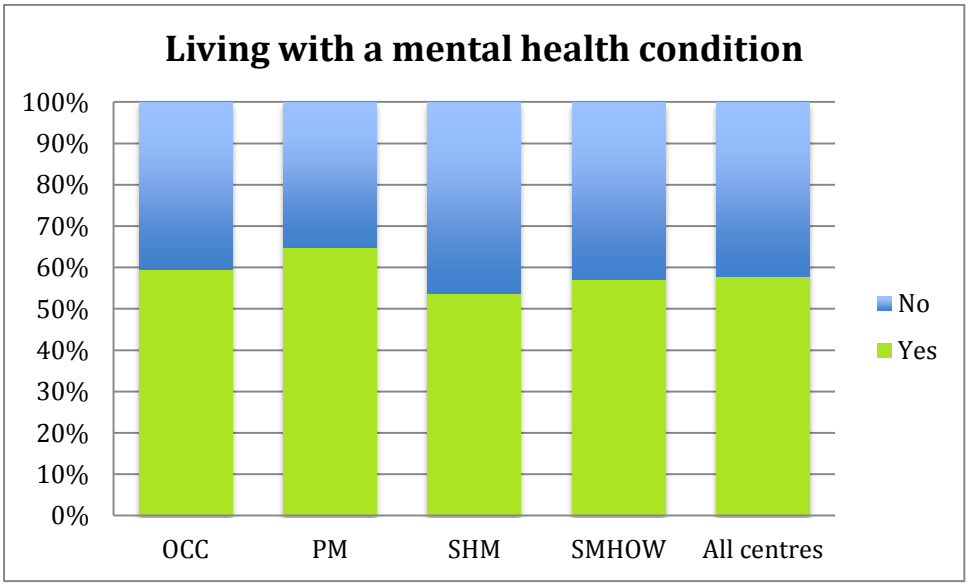
Survey respondents were asked if their mental health had stopped them from doing what they wanted or needed to do in the four weeks prior to interview. Half of the sample said that it had, with some difference between centres for frequency of occurrence.

Figure 24: Mental health obstructing daily life



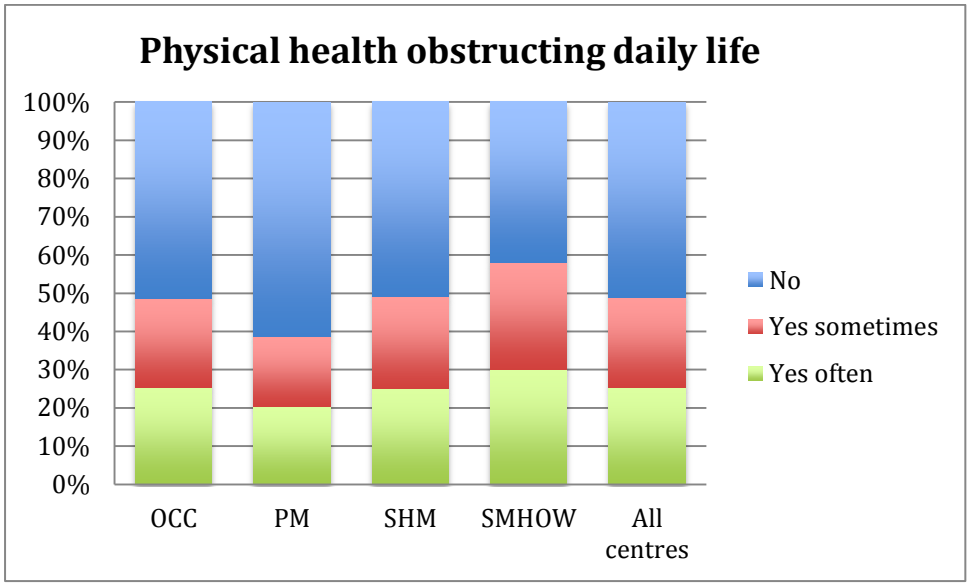
More than half the sample (58%) said that they regarded themselves as living with a mental health condition or illness, with little variation between the centres. The most common reported conditions were depression, anxiety, bipolar disorder and schizophrenia.

Figure 25: Living with a mental health condition



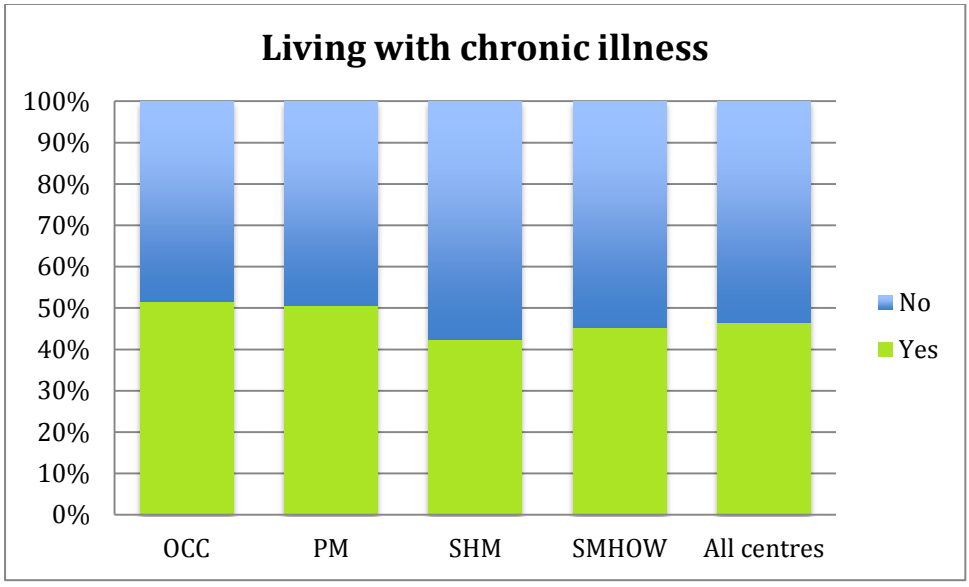
49% of the sample said that their physical health had stopped them from doing what they wanted or needed to do in the past four weeks.

Figure 26: Physical health obstructing daily life



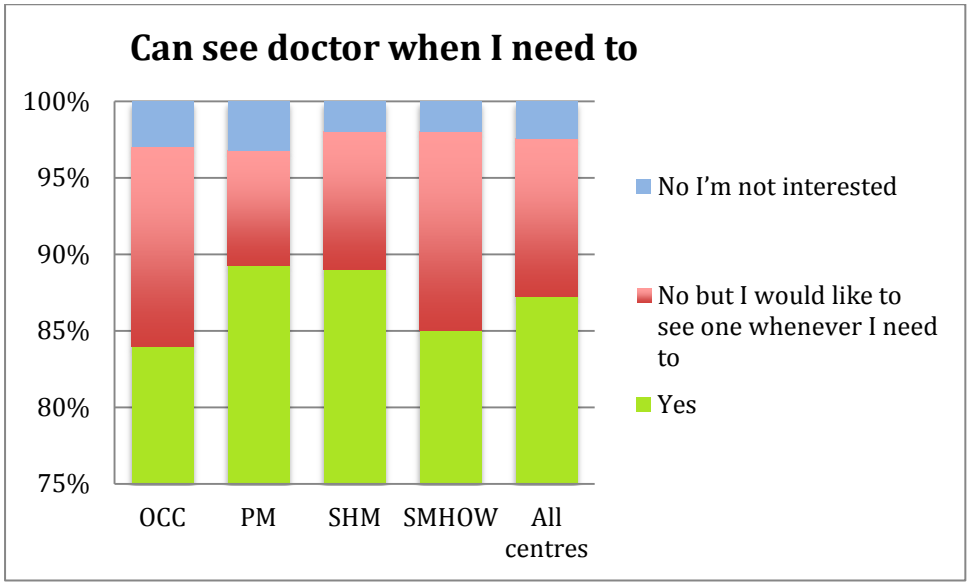
46% of the sample reported chronic disease or illness. The most common reported conditions were hepatitis C, heart conditions and arthritis. Some respondents also nominated mental health conditions here.

Figure 27: Living with chronic illness



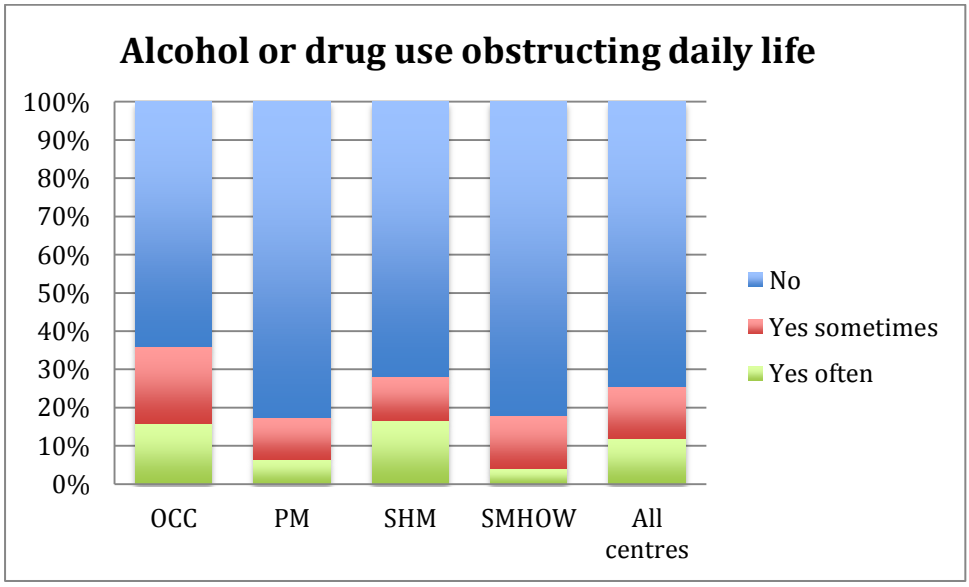
While 87% of the sample said they could access a doctor whenever they needed to, 10% said they were not able to, and a small number of respondents (12 people) were not interested in doing so.

Figure 28: Access to doctors



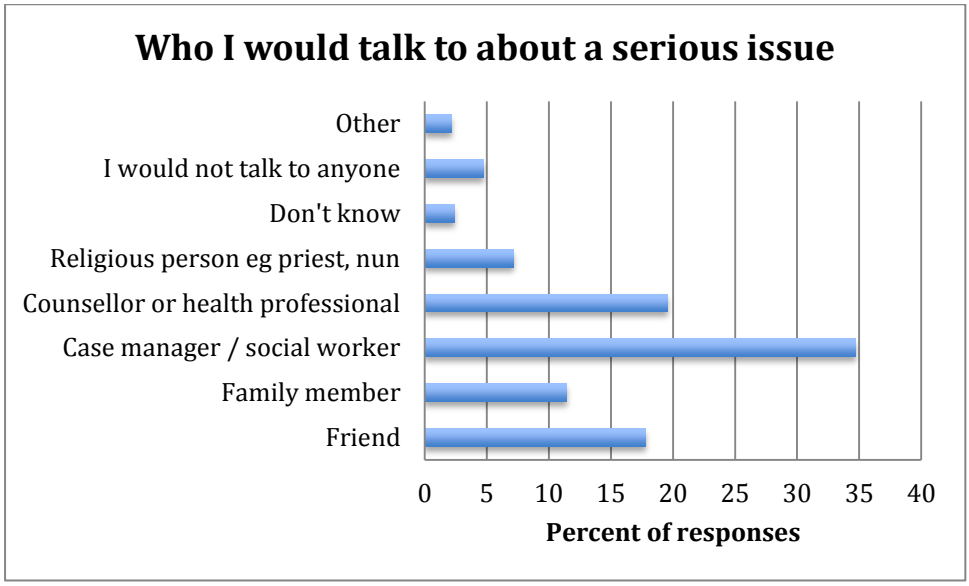
A quarter of the sample reported that their alcohol or drug use had stopped them from doing what they wanted or needed to do in the four weeks prior to interview. The proportions were higher at OCC (36%) and SHM (28%).

Figure 29: Alcohol or drug use obstructing daily life



Respondents were asked who they would go to if they needed to talk to someone about a serious issue. They could nominate more than one category of person.

Figure 30: Who to talk to about a serious issue



More than half the sample said they would speak to a counsellor, health professional, social worker or case manager, while less than a third (29%) nominated friends or family. This underlines the importance of the support provided by centre and visiting staff beyond meeting the material needs of clients.

Client Demographics: A Summary

The client sample is characterised by high levels of:

- past and present homelessness;
- unstable accommodation;
- physical and mental health needs; and
- physical and social isolation.

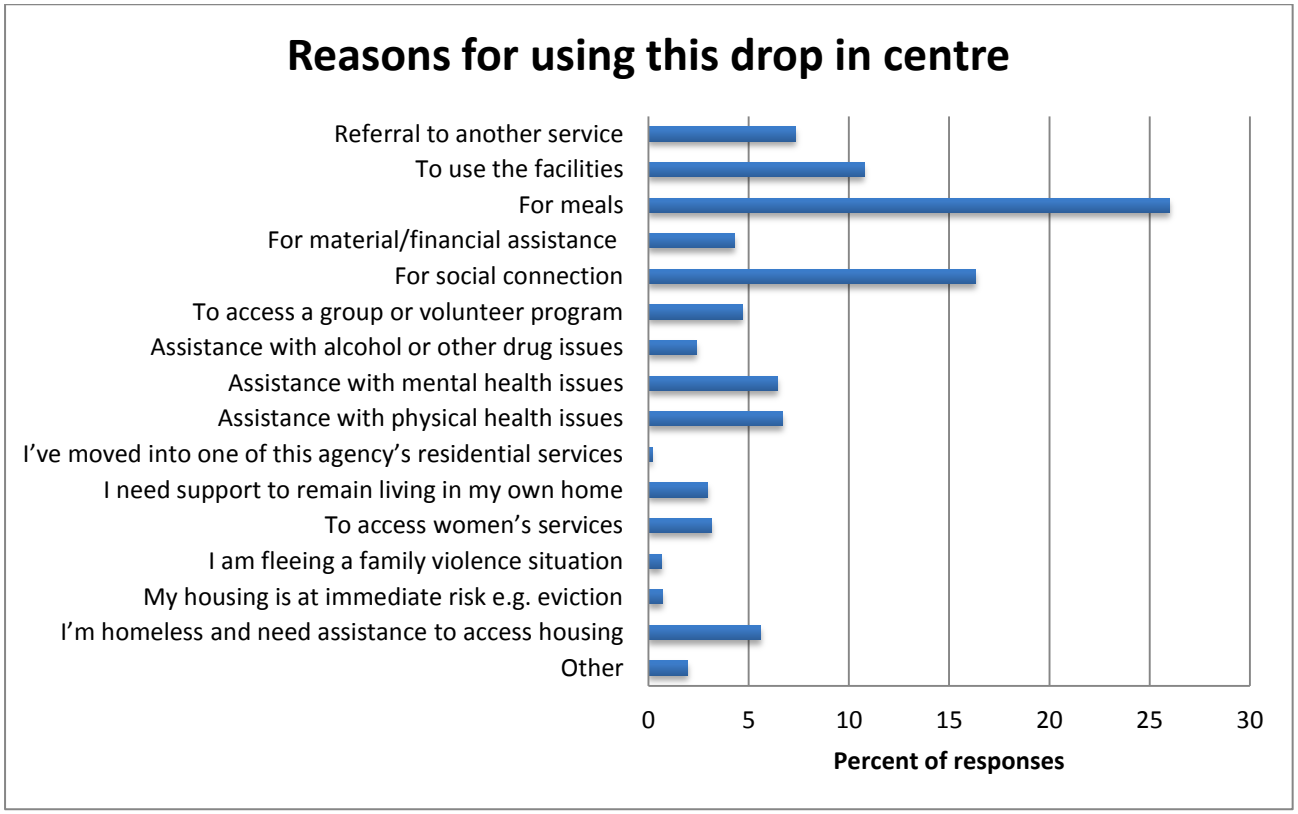
Nearly all respondents are dependent on social security benefits or pensions, and therefore on very low incomes. As such, the sample fits well with the intended client population of the Open Access centres, and with descriptions of client populations in the literature.

The sample is predominantly Caucasian, male and middle-aged, with very few people under 25. These characteristics were evident also in the observation sessions undertaken for the project. While there are some notable differences between centres in proportions of genders and ethnicities, this remains the dominant demographic for the centres as a whole. OCC, SMHOW and SHM have increased female participation by improving safety factors for women. This was done at SMHOW through redesign of the entire centre. SHM offer a separate Women's House and OCC have a separate women's room to encourage access for women. The very low usage by people aged 18 to 25 may be accounted for by the existence of youth-specific services such as The Living Room and Frontyard, which is a direct reflection of specific policy initiatives encouraging younger people to use youth specific services. In addition, some services are only available for individuals over 25 years of age.

Use of Centres and Services

The top three reasons survey respondents gave for using Open Access centres are for meals (26%), social connection (16%), and access to health services (physical and mental health, drug and alcohol – 15%). These three domains account for more than half of all responses. The next most common reasons are to use the facilities (shower, laundry etc – 11%), referral to another service (7%), and assistance to access housing (6%).

Figure 31: Reasons for centre use



People who are sleeping rough rely on the centres for their immediate practical needs. An in-depth interviewee on Newstart who was evicted from her private rental unit, and could not afford $220 per week for boarding house accommodation, was sleeping rough in her car. At the time of interview she had been attending a centre daily for three weeks while looking for work and a room in a shared house:

> *"I was in the car and no I couldn't have a shower, I couldn't go to the toilet and this that and the rest of that. I mean, being able to do those things does put you in a better frame of mind so that you can go out… and actually say, 'Well, man, I could make friends. I could get a job. I could do this, I could that.'"*

Stably housed clients on very low incomes also rely on the centres for access to multiple services, especially as they get older. A typical example is a 56-year-old man with arthritis in his hips and knees who attends his centre regularly for socialisation and recreation, and also for his medical needs:

> *"It gives me a bit of relaxation time from being at home, and it gets rid of a lot of boredom. If there's times when I need to see the doctor, then the doctors come in useful here. The same goes for Centrelink and the dentist (…) When I was living on the streets the only thing I was doing was just hanging around the city, which eventually leads to trouble. If I've got somewhere like this place to come to, it gives me stability. It also keeps me out of trouble."*

It is notable that the second most common purpose for using the centre is entirely non-utilitarian: to make social contact. One interviewee on the Disability Pension explained his reason for attending daily:

> *"The socialisation thing for most of us. It's a reason to get out of bed on a regular basis, because we're not working. It gives us a purpose, because all human beings need a purpose."*

A man who became homeless at age 58 for the first time in his life, having experienced a physical injury, loss of employment and relationship breakdown, explains why he attends his centre:

> *"Somewhere to spend the day when I'm looking for work. I'm on Newstart. You can only look for work so many hours of the day. You can only do nothing with nothing so long before you're bored out of your head. This is a good place. They've got programs, drama and so on to get into (…) I'm here almost every day now because I love playing pool. It's free. I look for jobs in the afternoon and stuff because it's closed. That's most of my days, here in the morning and looking for work in the afternoon, day after day after day (…) I used to be the person that volunteered at places like this, never dreaming that I'd actually be a client."*

There are some gender differences in reported reasons for use. The table below breaks down reasons for use by gender:

Table 10: Gender differences in reasons for using centres

Reasons for attending	Percent of respondents	
	Female	Male
I'm homeless and need assistance to access housing	21.9%	19.0%
My housing is at immediate risk e.g. eviction	3.9%	1.9%
I am fleeing a family violence situation	7.0%	0.5%
To access women's services	42.2%	0.0%
I need support to remain living in my own home	13.3%	9.1%
I've moved into one of this agency's residential services	0.0%	0.8%
Assistance with physical health issues	21.1%	23.9%
Assistance with mental health issues	23.4%	22.0%
Assistance with alcohol or other drug issues	9.4%	8.0%
To access a group or volunteer program	25.8%	13.2%
For social connection, seeing people, meeting friends	64.1%	54.1%
For material and/or financial assistance or support	24.2%	11.8%
For meals	89.8%	90.9%
To use the facilities e.g. showers, laundry, computers and internet, phone charger	39.8%	36.8%
Referral to another service	34.4%	22.8%

Apart from women-only services, women use the centres more than men for fleeing family violence situations, material or financial assistance, accessing group or volunteer programs and referral to other services.

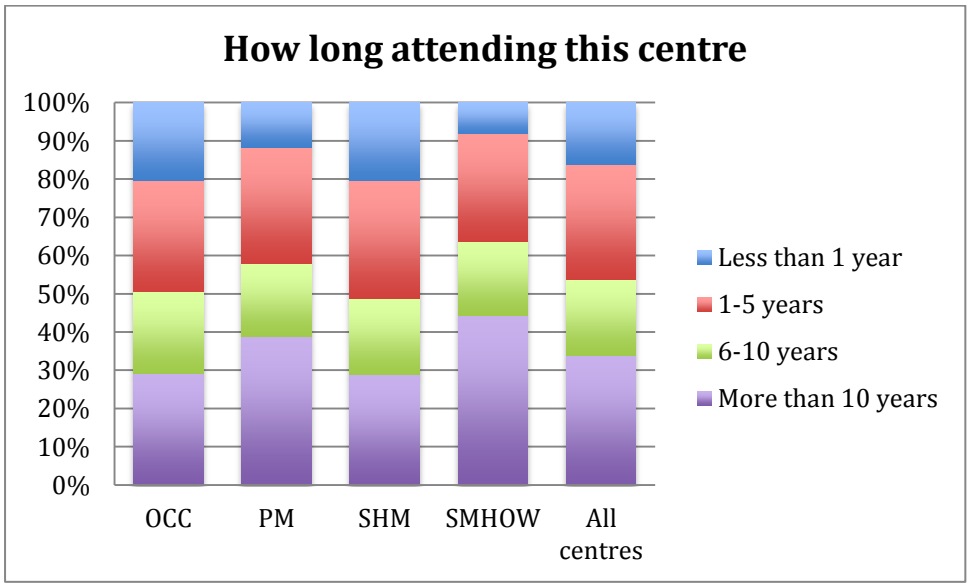
Table 11: Differences among people with and without Disability Pensions aged under 65 years in reasons for using centres

Reasons for attending	Percent of respondents	
	No Disability Pension	**Disability Pension**
I'm homeless and need assistance to access housing	23.6%	16.5%
My housing is at immediate risk e.g. eviction	3.9%	1.9%
I am fleeing a family violence situation	7.0%	0.5%
To access women's services	42.2%	0.0%
I need support to remain living in my own home	13.3%	9.1%
I've moved into one of this agency's residential services	0.0%	0.8%
Assistance with physical health issues	21.1%	23.9%
Assistance with mental health issues	23.4%	22.0%
Assistance with alcohol or other drug issues	9.4%	8.0%
To access a group or volunteer program	25.8%	13.2%
For social connection, seeing people, meeting friends	64.1%	54.1%
For material and/or financial assistance or support	24.2%	11.8%
For meals	89.8%	90.9%
To use the facilities e.g. showers, laundry, computers and internet, phone charger	39.8%	36.8%
Referral to another service	34.4%	22.8%

Table 11 shows that among people aged under 65, those with Disability Pensions were more likely than those without Disability Pensions to use Open Access services for support to remain living in their own home, and for mental health services and facilities.

Just over half of the survey sample (54%) first attended the centre at which they were interviewed more than five years ago:

Figure 32: How long attending centre



Centres with more stably housed clients – PM and SMHOW – have more clients who have used their centres over many years. The centres with less stably housed clients – OCC and SHM – have more new users and fewer long-term users.

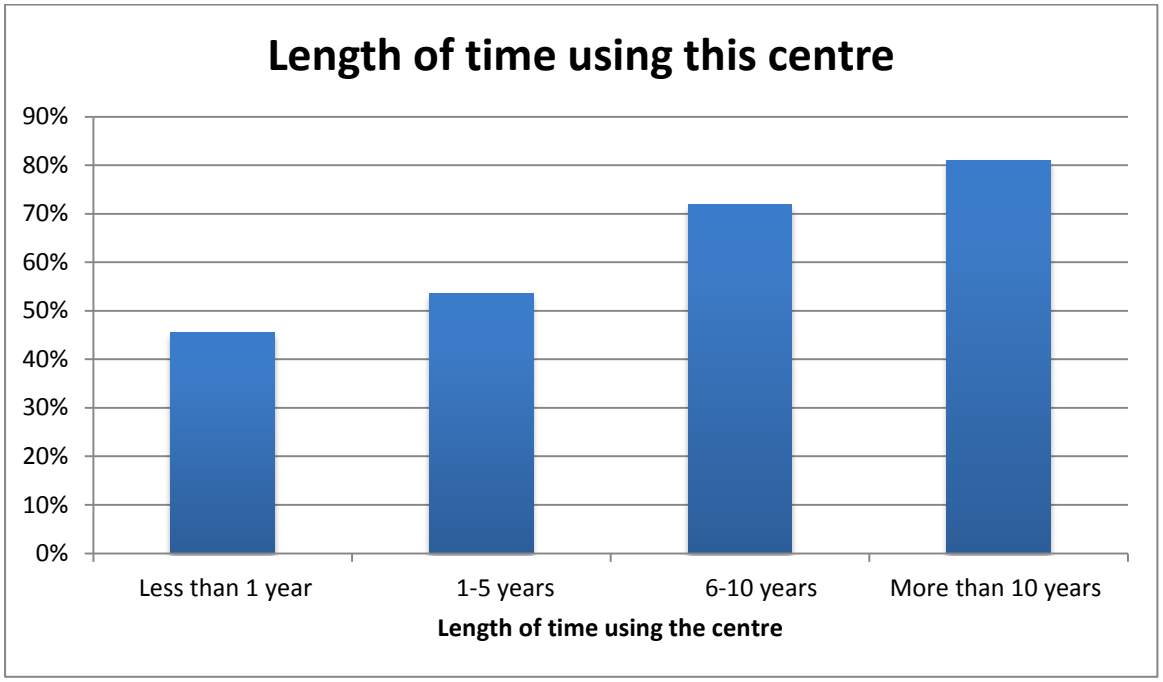
This would indicate that the centres' function is not only to meet people's immediate critical needs. They also service their clients' longer-term needs that are not being met by mainstream services and community facilities.

Some people use the centres periodically over the longer term while others attend continuously. The long-term usage patterns of two clients interviewed for this study illustrate this point:

- A woman born with spina bifida who has been attending her centre regularly for more than 10 years experienced assaults and sexual harassment while living in boarding houses, and was homeless for five years before her centre helped her find safe, secure housing. She still suffers from PTSD and agoraphobia. She is on a Disability Pension and attends her centre regularly for counselling, meals and social contact.
- A man who lost his permanent accommodation after being blamed for property damage carried out by someone else has been sleeping rough for the past three months. He currently attends his centre daily for breakfast, showers, clothes washing and sporting activities. He used the same centre when he was homeless on two other occasions – four years ago and 18 years ago.

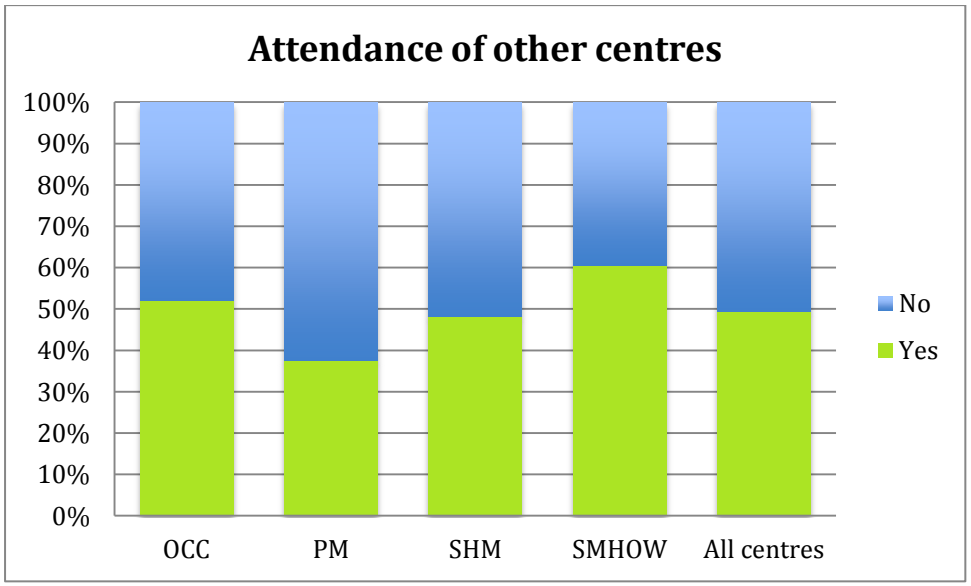
Figure 33 shows the percentage of people with Disability Pensions in each length of attendance category. Among people under 65, those with Disability Pensions were over-represented in longer-term users. It is not clear from this study whether this reflects periodic or continuous use.

Figure 33: Under 65s with Disability Pensions by how long they have been attending centre



Many clients – about half of the survey sample – also attend other centres, not just the ones they were interviewed at:

Figure 34: Attendance of other centres



The in-depth interviews revealed varied reasons for using more than one centre. One man said he used to visit a different centre when his mental health was worse, but now she feels improved he prefers not to go there. Another man has meals at centres in the far south-eastern suburbs of Melbourne every week to break his routine and catch up with old acquaintances. Also, those who

are sleeping rough, who know the operating hours and facilities available at various centres around Melbourne, and use the different services to cover their needs as much as possible seven days a week.

Nevertheless, most interviewees tend to indicate a sense of loyalty or belonging with their preferred centre. On this topic, one interviewee said:

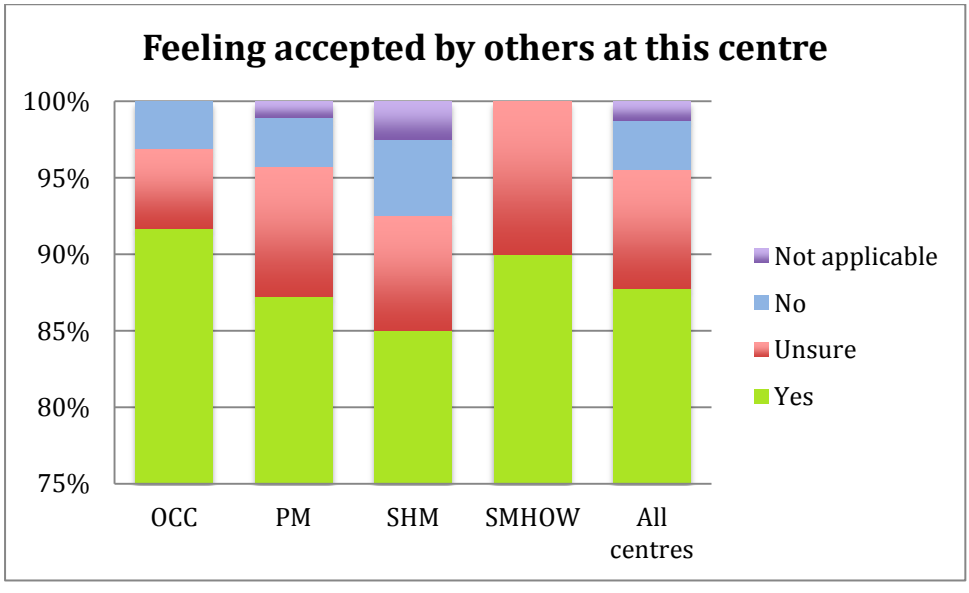
> *"A sense of belonging becomes more important to people with mental health [issues] than so called 'normal' people, because normal people have more friends. They have a job, they have more social... They have more money to spend on social activities, education programs, and so forth, and are able to allocate their time a lot better, because they're more functional."*

For some, their centre is the only place they feel they can go:

> *"There is nowhere I could actually even comprehend going, nowhere else I feel safe and trusting with my story and I know a lot of the people here. Particularly growing up in the area as well. There's a lot of new faces, a lot of old faces, a lot of faces that have died but I feel safe here."*

When interviewees were asked if the Open Access centre was a place where they feel accepted by others, a resounding 88% of the sample said yes. This is a substantial increase from the sample's response to the earlier question of whether they felt part of their local community, which averaged a 64% yes.

Figure 35: Acceptance by others at the centre



Interestingly, at the centre where attendees felt most isolated from their local community – OCC, with only 52% feeling part of it – the most clients felt accepted by others at their centre, with 92% answering yes to this question.

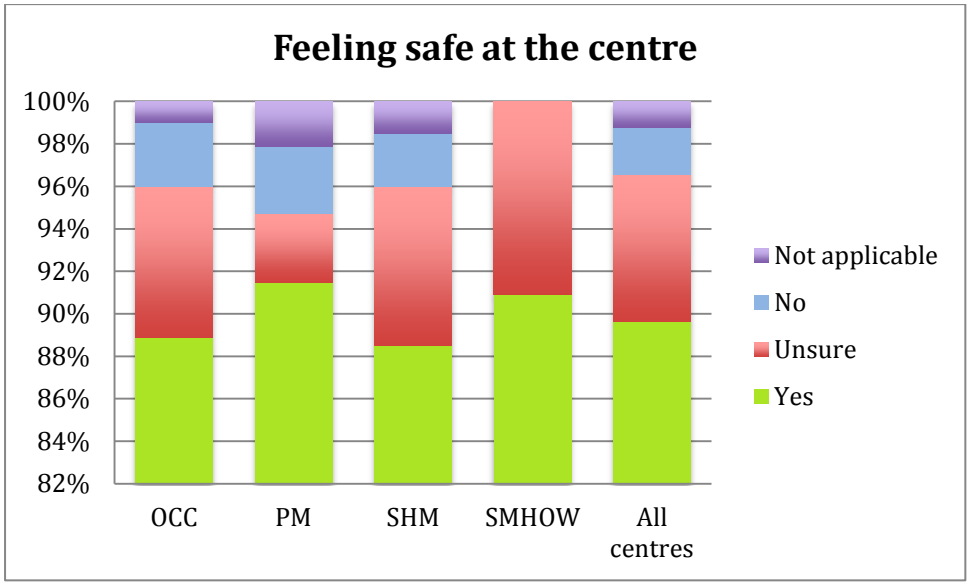
These results point to the value of Open Access centres as an instrument of social inclusion for people who otherwise experience social marginalisation. In-depth interviewees spoke about this frequently:

> *"Here I'm not made to feel dirty, I'm made to feel valued and made to feel that I do belong and I am not on the outside looking in or invisible completely to society."*

> *"I made a few acquaintances and some good friends here. I feel I belong here. That's important because a lot of us people who are sick are isolated and they tend to choose to be isolated because it's very confronting. Life, reality, people in the normal situation, in the work situation. Even in a social situation because the pension is enough, it keeps you going but it doesn't give you a lifestyle (…) It's a place where you can come and associate, have a chat, have a coffee, have lunch (…) This is like my home away from my home."*

90% of the survey sample feels safe at their Open Access centre. This means that many feel safer at their centres than where they live, where only 79% feel safe (see Fig. 16). This trend occurs at all centres except the more stably housed SMHOW client group, which feels slightly safer at home.

Figure 36: Feeling safe at the centre



The table below shows that in the survey sample there is little difference between men and women in feeling safe at the centres:

Table 12: Gender differences in feeling safe at the centre

Gender	Feel safe at the centre			
	No	Unsure	Yes	Not applicable
Female n=127	2.4%	8.7%	87.4%	1.6
Male n=361	2.2%	6.4%	90.3%	1.1

Several in-depth interviewees did voice some concerns over safety, mentioning that incidents do happen occasionally at centres. Nevertheless, most said they felt safe at their centres, with staff vigilance being the primary explanation for this:

> *"The staff here are pretty good, you know? They know how to handle the situation when it comes up. They don't tolerate nonsense, you know what I mean? If someone comes in aggressive, and carrying on, they'll try to soothe them down. They don't want to listen, fine, there's the door. They want this place to be as safe as possible, we do as well. We don't want to come in here and feel unsafe that someone's going to hurt me, or someone's going to do that."*

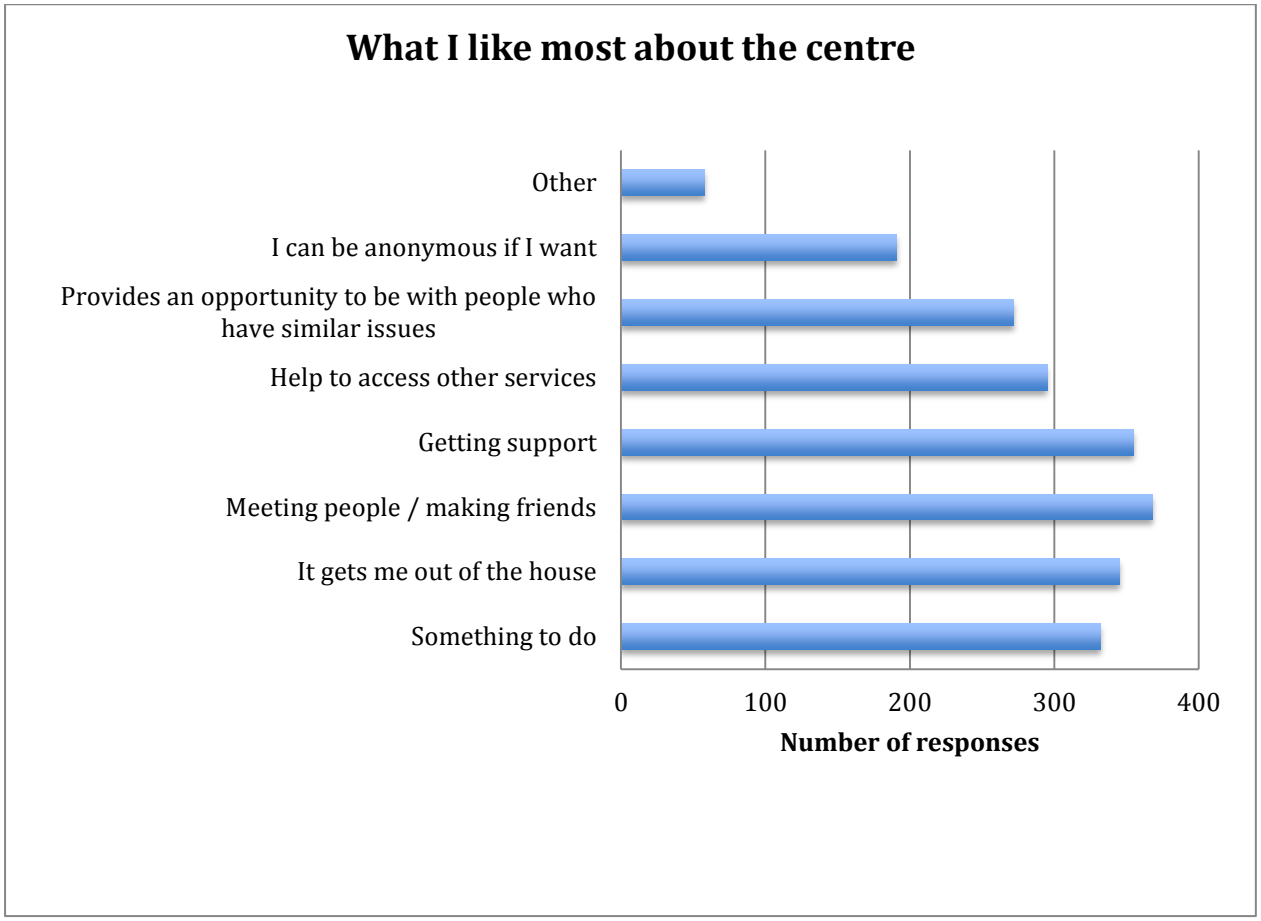
> *"I think it's successful because of the staff, the way they treat the clients (…) We haven't had a really bad incident here for a long time. We have argy bargy, push and shove but that's part and parcel of the guys (…) Because the location here, it should be as rough as everywhere else (…) I just think the staff go a long way to making the centre what it is."*

One interviewee said she would feel safer if there were security cameras or a guard at her centre, which would in turn attract more women and improve her experience there. Another said that without the Women's House at her centre, many women could not attend at all:

> *"Some of the women that come here, this is the only socialising they maybe do all day. Then they go home to, possibly, their room or their flat. They don't want to go up to the main centre because there's men there. See, that doesn't worry me, but I prefer to be here with the women. It's a nice atmosphere. On the weekends, I would go up to the main centre and meet with the guys, but some of these women here can't do that… They're too frightened to walk into that environment."*

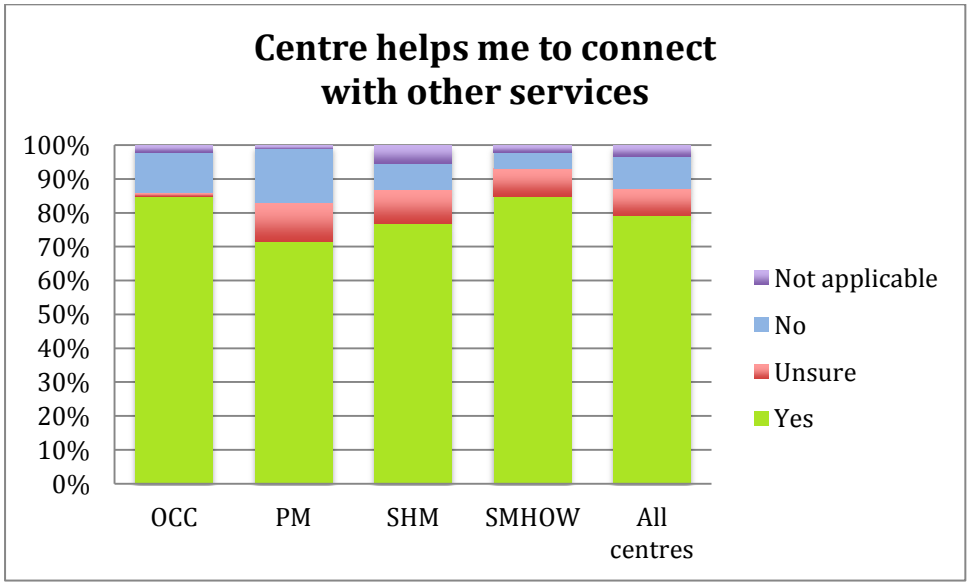
Survey respondents were asked what they liked most about their Open Access centre. This question elicited 2216 responses. The most popular response, with 368 ticks, was 'Meeting people and making friends'. The most common free responses in the 'Other' category relate to meals and centre staff.

Figure 37: What respondents like most about the centre



A large majority of the survey sample (79%) agreed that the centres help them to connect with other services and programs.

Figure 38: Helps connect with other services



Many in-depth interviewees also reported that centre staff helped them to access external housing and health services. One client, who used to be homeless, commented:

> *"If I hadn't had the outreach worker here, I wouldn't have gotten the government housing. You actually need one now if you're not seeing one, otherwise they won't accept you."*

Some clients would not access vital services without the involvement of centre staff:

> *"Without people in these places, I wouldn't even bother going to the doctor's. If I walk in here, I've got blood dripping down my leg, the first thing they say is 'Look, go straight up the doctor's, get it checked.' They don't want you sitting there in pain, what have you. If they have to they'll take you up there themselves, you know? That's how they are. Without them, I wouldn't even bother. I'd tell them, 'Yeah, don't worry about it."*

Similarly, some clients are lacking the capacity or experiential knowledge to access services independently. One interviewee with memory and visual impairment relies on his case worker at the centre to know when his medical appointments are (Client 2K). Another interviewee lived most of his life in institutions: he was a ward of the state since infancy and spent the first 16 years of his adult life in prison. He is now living in supported accommodation run by his centre:

> *"It was hard for me to adapt into the fast world that's changed since when I went in in 1995 and didn't get out until 2009 (…) I don't have a clue about all this. I'd probably have to... I don't know... I'd be lost."*

Service usage

The survey explored in detail clients' usage of services, including how they accessed services. Interviewees were asked whether they had used any of a list of services within the past year. They were also asked whether the centre provided the service, or referred them to another venue operated by the same agency, or referred them to a different agency, or if the centre was not involved at all in accessing the service.

The following charts show service access broken down by the four distinctions of how clients accessed services. Please note that the percentage figures on the left axis of the charts refer to the group of interviewees who used that type of service, not the whole client sample. The numbers of service episodes are provided in the accompanying table below each chart.

Figure 39: Service usage and referral (1) – relative percentage

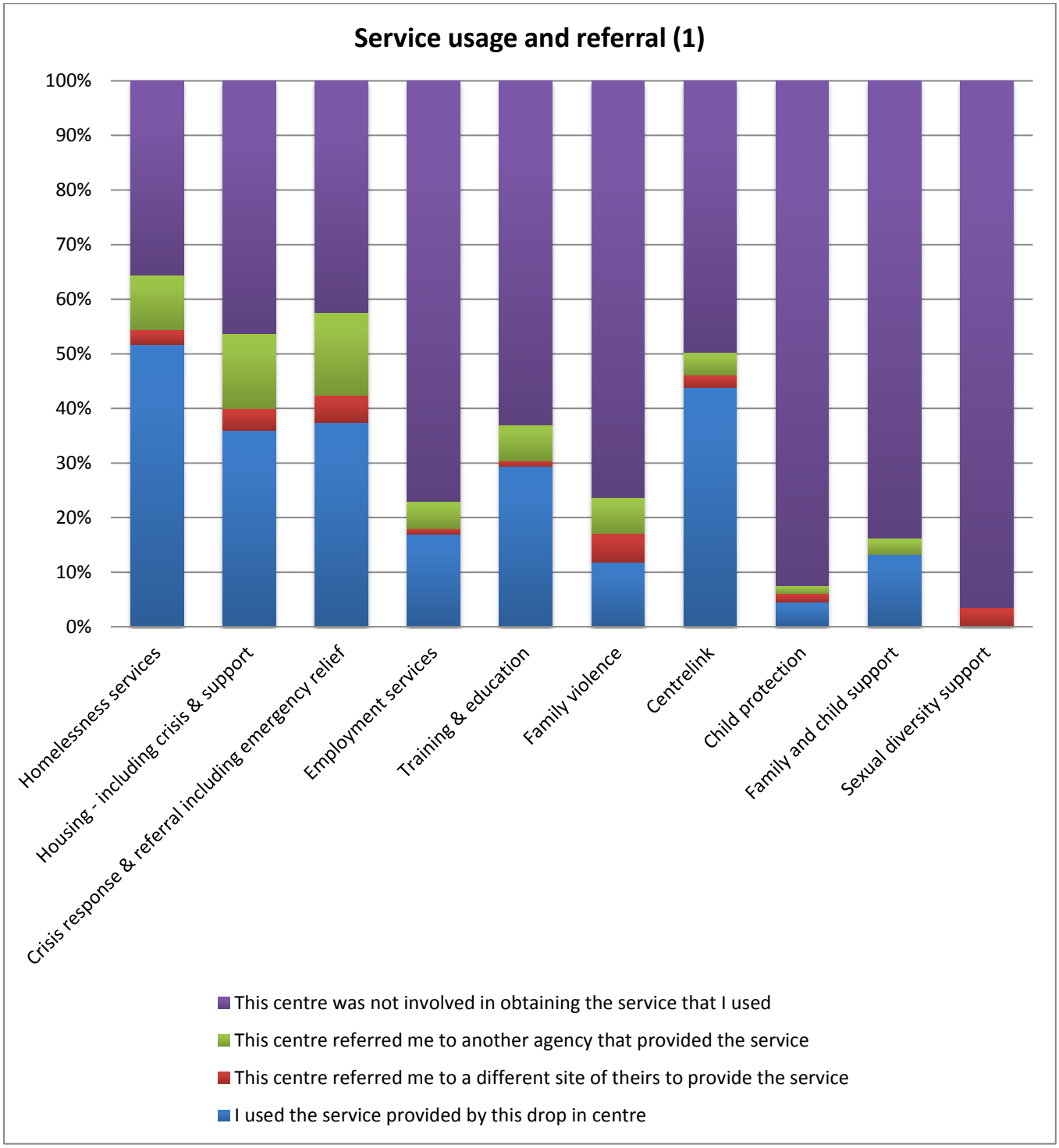


Table 13: Service usage and referral (1) – number of service episodes

Service	Access type				
	I used the service provided by this drop-in centre	This centre referred me to a different site of theirs to provide the service	This centre referred me to another agency that provided the service	This centre was not involved in obtaining the service that I used	*Totals*
Homelessness services	119	6	23	82	*230*
Housing – including crisis and support	63	7	24	81	*175*
Crisis response and referral including emergency relief	59	8	24	67	*158*
Employment services	17	1	5	77	*100*
Training and education	27	1	6	58	*92*
Family violence	9	4	5	58	*76*
Centrelink	95	5	9	108	*217*
Child protection	3	1	1	61	*66*
Family and child support	9	0	2	57	*68*
Sexual diversity support	0	2	0	56	*58*

Figure 40: Service usage and referral (2)

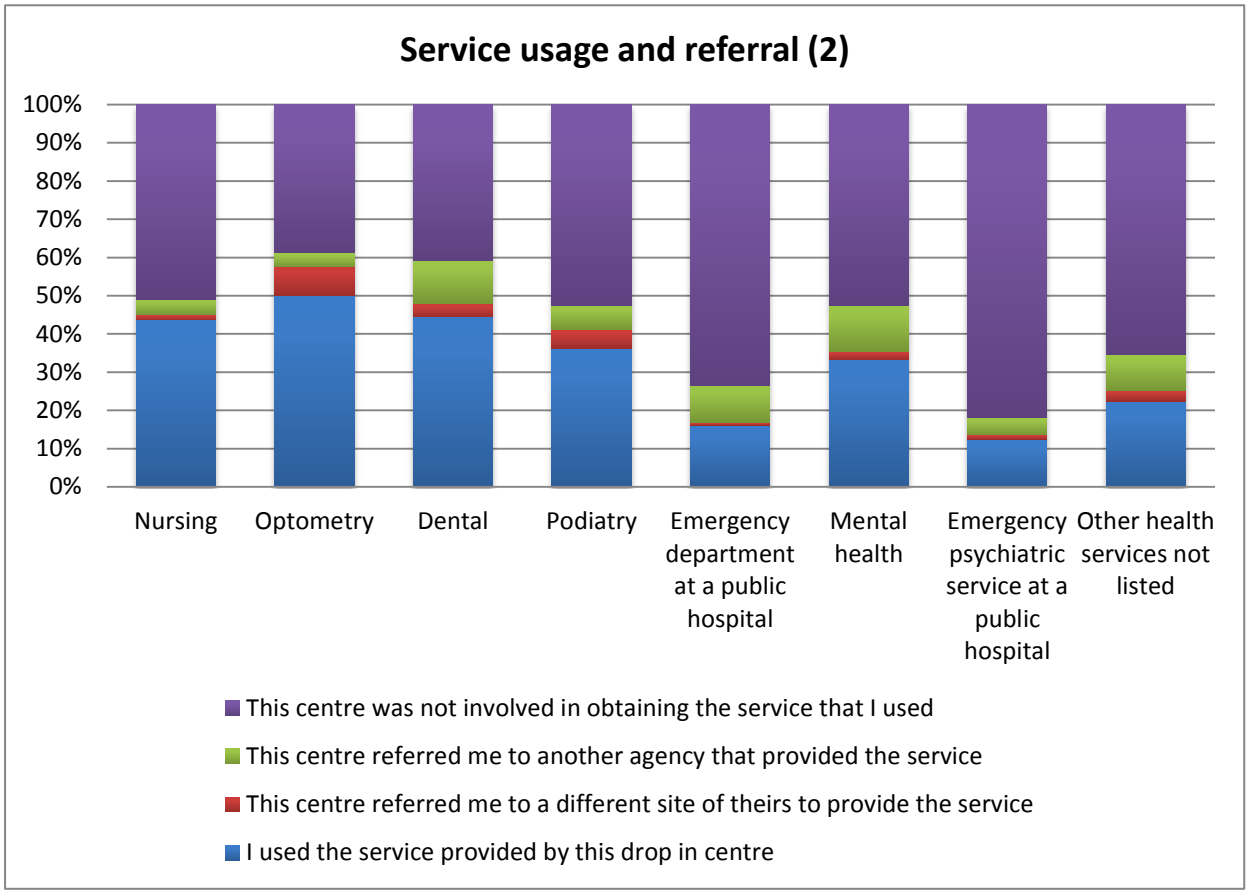


Table 14: Service usage and referral (2) – number of service episodes

Service	Access type				
	I used the service provided by this drop-in centre	This centre referred me to a different site of theirs to provide the service	This centre referred me to another agency that provided the service	This centre was not involved in obtaining the service that I used	*Totals*
Nursing	66	2	6	77	*151*
Optometry	85	13	6	66	*170*
Dental	88	7	22	81	*198*
Podiatry	51	7	9	74	*141*
Emergency department at a public hospital	20	1	12	91	*124*
Mental health	47	3	17	74	*141*
Emergency psychiatric service at a public hospital	11	1	4	72	*88*
Other health services not listed	24	3	10	70	*107*

Figure 41: Service usage and referral (3)

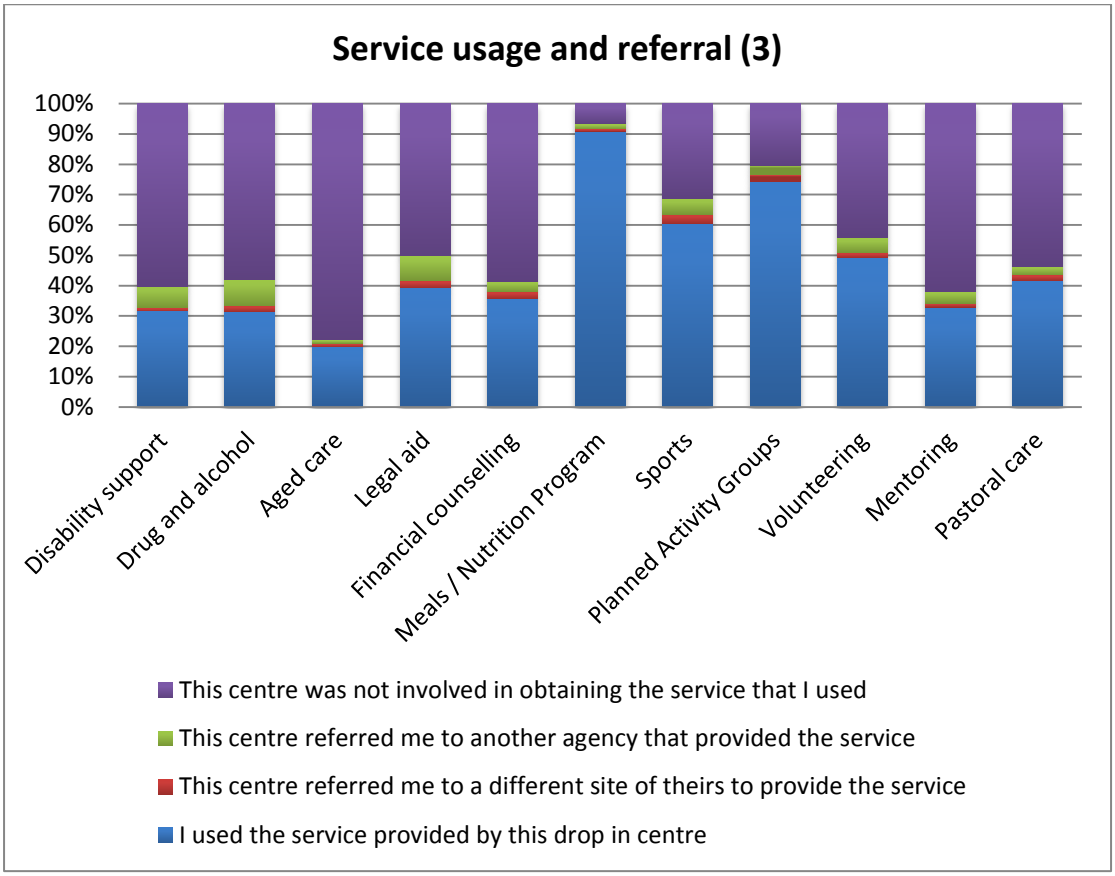


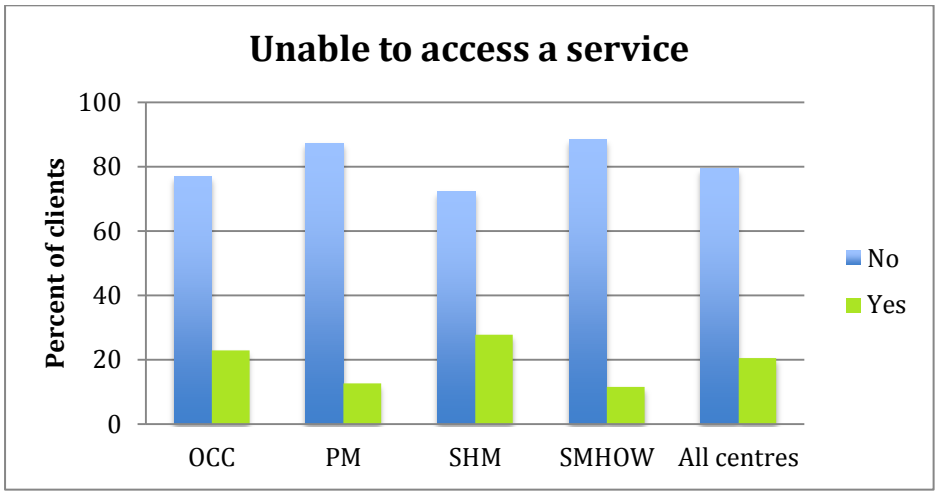
Table 15: Service usage and referral (3) – number of service episodes

Service	Access type				
	I used the service provided by this drop-in centre	This centre referred me to a different site of theirs to provide the service	This centre referred me to another agency that provided the service	This centre was not involved in obtaining the service that I used	*Totals*
Disability support	31	1	7	59	*98*
Drug and alcohol	33	2	9	61	*105*
Aged care	16	1	1	63	*81*
Legal aid	51	3	11	65	*130*
Financial counselling	31	2	3	51	*87*
Meals / Nutrition Program	381	3	7	28	*419*
Sports	81	4	7	42	*134*
Planned Activity Groups	142	4	6	39	*191*
Volunteering	60	2	6	54	*122*
Mentoring	25	1	3	47	*76*
Pastoral care	45	2	3	58	*108*

Figures 39 to 41 show that clients rely heavily on core centre services, including homelessness and housing support, crisis response and referral, allied health and counselling services, and social and sports programs.

Clients were also asked if there were occasions in the past four weeks when they needed a service from the centre but could not access it for any reason. 21% of respondents said there were.

Figure 42: Inability to access a service



The centres that offer more types of services – OCC and SHM – had higher percentages of clients reporting inability to access a service. The most common reasons people gave for not being able to access a service were: lack of service staff, centre funds, facilities or available appointments, and the centre being closed on weekends or public holidays.

The in-depth interviews showed that weekend closures (though SHM Central is open at weekends) can be difficult for people who rely on the centres for social contact and support:

> *"Socialising on a weekend, if you don't have money, where you going to go? Where do you go? It heightens the sense of loneliness because everyone's got someone to talk to. You're just sitting there by yourself. I mean you're watching things but you need to have a chat."*

Social activity outside of Open Access centres

Clients were asked whether they participated in a range of activities outside of the centre, and if so, how often:

Figure 43: Participation in activities outside of Open Access centres – relative percentage

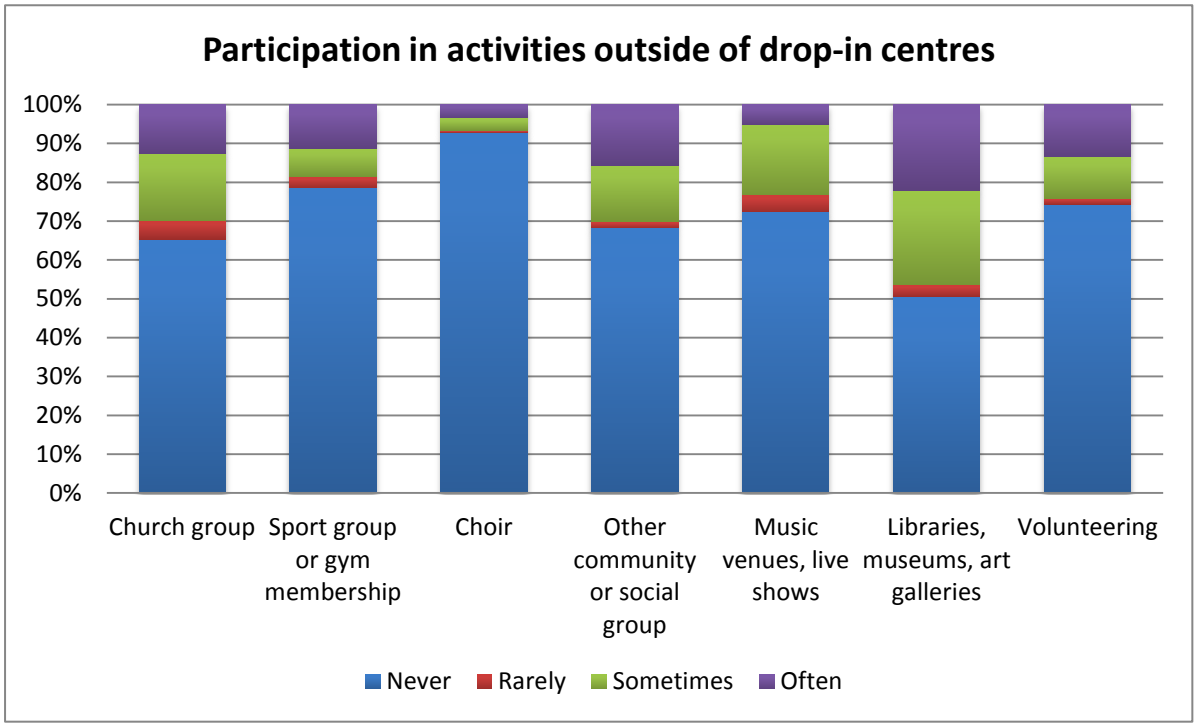


Table 16: Participation in activities outside of Open Access centres – number of responses

Activity	Level of participation				
	Never	Rarely	Sometimes	Often	*Total responses*
Church group	285	21	75	55	*436*
Sport group or gym membership	330	12	30	48	*420*
Choir	375	2	13	14	*404*
Other community or social group	279	7	59	64	*409*
Music venues, live shows	298	18	75	21	*412*
Libraries, museums, art galleries	223	13	107	97	*440*
Volunteering	287	6	41	52	*386*

Activities likely to involve monetary cost, such as live shows and sports or gym programs, show regular participation from a quarter or less of the survey sample. Activities that can be accessed at no cost such as libraries, church groups and other community groups show participation by up to half of the sample. Overall the results indicate very limited participation in community activities outside of the Open Access centres.

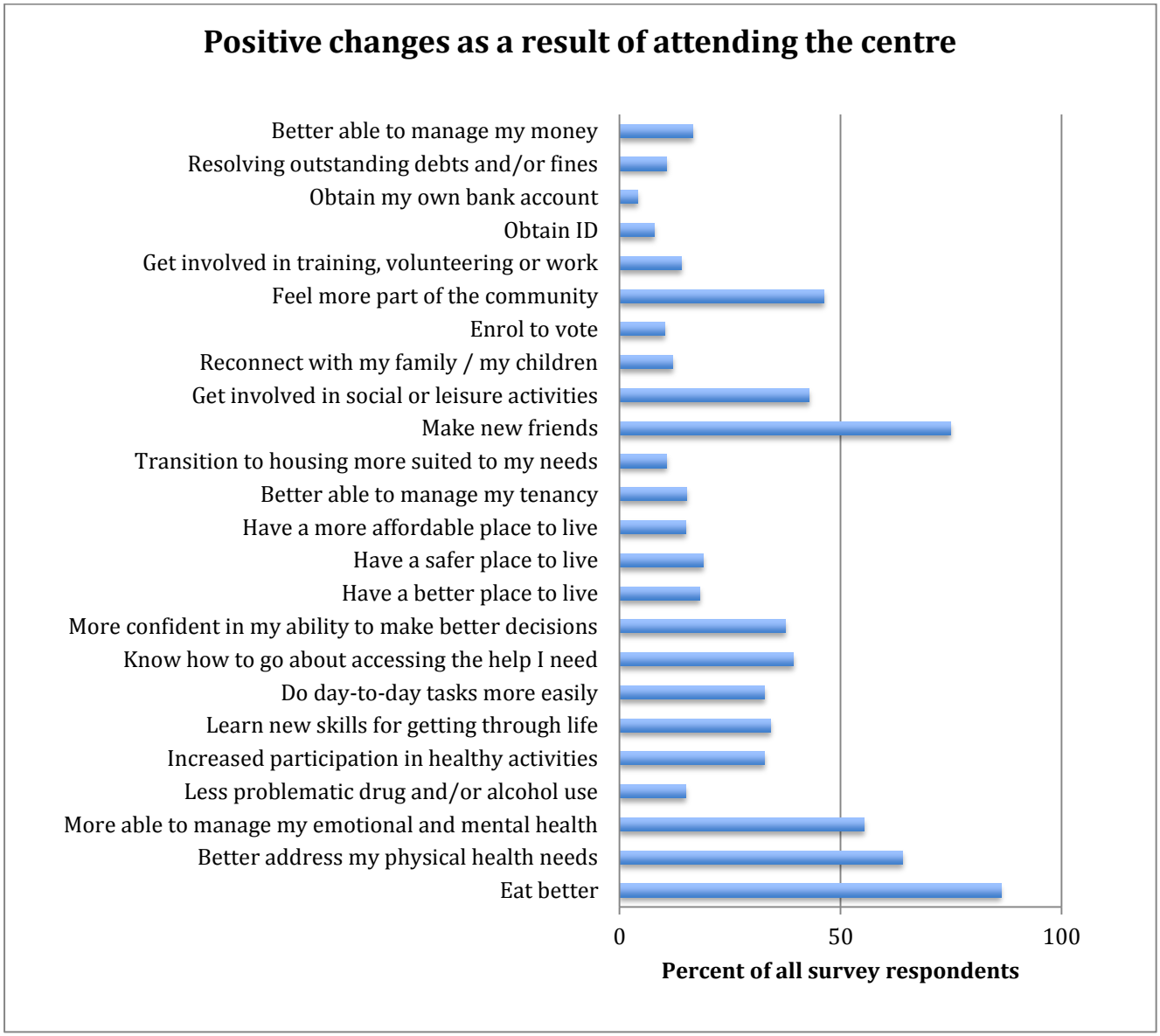
This finding is supported by the in-depth interviews. One typical observation is from a client aged 68 who attends his centre every weekday, then visits his local library after it closes. He would like the centre to have longer opening hours and more activities, and says if the centre did not exist, he'd *"probably just be rotting at home".*

Benefits and Unintended Outcomes

Benefits

Survey clients were asked if they had experienced positive change as a result of attending the Open Access centres. The question received 3544 reports of positive change across a range of domains. These responses are summarised in the chart below, which more than any other statistic encapsulates the benefits of attending Open Access centres:

Figure 44: Positive changes as a result of attending the centre



The benefits accruing to centre users can be grouped under four interconnecting domains:

- Social inclusion
- Health
- Housing
- Life skills

Before addressing these four aspects, it should be noted that for many centre users – in deep personal crisis, or sleeping rough, or without any finances at all – attending an Open Access centre can be very helpful in a number of different ways. When invited to leave a final comment at the end of the quantitative survey, several respondents made statements such as these:

> *"The nurse here saved my life as she picked up on what was happening to my health."*
> *"I seriously don't think I can cope or live without this service. My life has changed dramatically since I walked through their doors."*
> *"It saved my life."*

One in-depth interviewee who lives in public housing across the road from her centre recounted how the centre nurse saved her life by checking on her at home when she didn't turn up for her appointment. She was found collapsed on the floor with severe pneumonia, and spent nine weeks recovering in hospital.

Social inclusion

Consistently throughout the survey results, the in-depth interviews and the academic literature, social contact serves as a primary motivation and benefit for centre clients, many of whom are otherwise socially isolated, have physical or mental health conditions, and live at the economic margins of society.

There are few places those with little or no disposable income can go to spend a few hours and socialise if they choose, and play pool or chess or simply inhabit the same space as other people – especially if their appearance or behaviour does not fit in with mainstream social expectations of normality. Open Access centres provide the opportunities to do this.

Referring to Figure 44, 75% of survey respondents said they made new friends by coming to their centre, and 46% said they felt more part of the community. This echoes the comments of in-depth interviewees that attending the centres provides a feeling of belonging:

> *"It's like a second home. Some people, we've got our homes, but then this is like a second home and people that pass away or something happens to someone, it kind of affects you in a way. It's like, not like a brother or sister, but you'd get hurt because you've seen them for so many years. Usually when you hang out with your friends you see them just at restaurants or whatever else, but this is like a second home. You come here and you get used to these people, whether it's elderly or young or whatever, and they become a part of you."*

As the chart at Figure 35 shows, 88% of survey respondents said that the Open Access centre was a place where they feel accepted. Over half the survey sample have been attending their centres for more than five years (Figure 32).

There is no doubt that the centres function as communities for a large proportion of clients. Having at least one place where they belong and feel accepted can only strengthen clients' resilience,

confidence and self-esteem, and ultimately their physical and mental well-being. This sentiment was described by many in-depth interviewees:

> *"I get a great sense of friendship and care when I come here. I've got the staff to talk to if I need to. I get a great sense of pride coming here, self-worth (…) When my partner passed away, this has been a great source for me. I come here every day, talk to staff, you meet people, you've got someone to talk to (…) I can come and have a talk, have a cry. Plus I'm not sitting in my unit grieving away and pining away, feeling sorry for myself. I make myself go out, that's why I come here."*

> *"It gives you a reason to come out, feel at home here, feel comfortable (…) You spend about five or six hours of your day, go home and feel like yes, I've actually been out, I've actually done something. I've gotten involved in some of the activities here (…) If this wasn't here I'd probably be cooped up in my flat, being people shy sometimes because of my illness (…) When you're sensitive, you pick up on that, you take it to heart. That adds to my depression. I mean, it happens here too but here you're cocooned in a way, you've got staff who supervise you. If I didn't have this, I'm not really sure. Probably get sick again."*

> *"The socialisation thing for most of us. It's a reason to get out of bed on a regular basis, because we're not working. It gives us a purpose, because all human beings need a purpose (…) You learn that we're in the same boat. Irrespective of the degree of mental illness or loneliness or whatever is going on in our life, this is a point where we can come for a while and forget about what's happening or what happened in our past, because our mind is taken off those issues which may visit us at night, or when we're by ourselves. That's all I can say, really."*

> *"They want to help you have ambitions and passions and they want to bring you back into the community again, because that's where it all starts. Community is the best and once you're back into the community, you start loving yourself a lot more. Once you start loving yourself a lot more, you circulate positive energy again and you attract positive people in your life. I consider [the centre] to be family now, I really do. They've been better, they've been more of a family to me in the last 10 years than what my family actually have. I hate to admit that but that's the truth."*

Health

The single biggest contribution that centres make to their client population's health is nutrition through their meals programs. Every year the centres provide tens of thousands of meals to hundreds of clients. The survey results show that meals are the most utilised and most widely valued program the centres offer. This is consistent with the Open Access service model, that uses meals as tool for meaningful engagement. The in-depth interviews reveal that clients strongly appreciate the opportunity to eat nutritious meals regularly, commenting on how much better they feel as a result, how it makes dieting easier, and how it enables them to save money to pay for other life necessities:

> *"You wouldn't be getting the vitamins and the minerals and all the good things that you need for a reasonable diet if you weren't coming to these centres. You get quite lazy when you live by yourself. You just don't want to cook for one. It's partly your own fault*

as well. People just don't want to cook for themselves. If you're dished up a decent meal, you'll eat it. So, definitely, I think they're an absolute godsend."

"I'm as happy as I've ever been. It's improved my health enormously. I wasn't before, I wasn't eating properly. I've lost weight since I've been here. Probably the happiest I've been for years. I'm happy with my life."

"They teach us about nutrition. They also give us good balanced diets every day. I'll be honest with you, I'm not such a good cook, so they've taught me how to look after myself a lot better when they're not around at home. Without that, I wouldn't have known how to look after myself better."

"I've built a routine around coming here. I get my exercise, I get contact with people and get a meal which allows me to spend money on other things (…) I'm 65 and I want to have a little bit of money put aside for when I get older. I'm getting cataracts in my right eye and I'm toiling with the idea to have that done privately. I had to spend, I did have crowns on my teeth. I had my teeth all taken out and false teeth (…) It allowed me to do that. I don't spend money on drugs. A lot of people do."

"My financial situation is dire, it's literally down to single dollars so I have to be very, very careful, very, very, savvy and I have to take more responsibility in paying certain bills immediately than what I used to. Could save me $25 a week just from having three or four meals here weekly, five meals here weekly, easily. Yes, it does make a difference (…) A lot of men my age are struggling to, particularly when they've been in work for many many years, really struggling to come to the terms of living on Newstart."

Of the clinical health services on offer – such as nursing, dentistry, optometry and podiatry – the survey data show that around 50% of clients who use these services rely on the centres to access them, either directly on site or indirectly by referral. The provision of podiatry indicates the thoughtfulness behind centre programming; people who are homeless spend a lot of time on their feet. The majority of in-depth interviewees access these types of health services at or through their centres, where possible.

It was noted during the observation sessions that allied health staff practice outreach at centres, initiating informal conversations with centre users to perform mini-assessments and arrange appointments for them. Allied health staff also consult with centre staff to gather information about clients who are difficult to engage.

The centres also provide a range of other services and programs aimed at improving well-being, including mental health and disability support, drug and alcohol counselling, and sports and activities groups. One-third to three-quarters of clients surveyed rely on the centres to access these types of programs. 55% of survey respondents say they are better able to manage their emotional and mental health as a result of attending the centres (Fig. 44). These results are backed up by in-depth interviewees' observations on their own experiences:

"I remember when I first came here I had a really bad anger problem. I was always angry all the time. I'd blow off all the time. Since I've been here I've learned to manage my

anger and if I get angry I've learned strategies, how to calm down if someone annoys me, how to walk away. I don't let them get to me. I know how to do that now. Strategies how to cope with that, not to get mad. They've seen the change in me since I've been here to now, which is really good. They're so proud of me, they say 'pat yourself on the back'. I've done so well. I'm so proud of myself (…) I think it's because of all the support, having them there, talking to them all the time, being there, listening to me. Someone listening to me and actually helping me, it was really good."

"Unfortunately, in this world today with so many people particularly in my situation unemployed, there are a lot of vices out there in the world. Drugs or even just mixing with the wrong type of people, and when money is so tight or so difficult to come by, when you're living simply on benefits you can't afford to make any mistakes. The beauty about full-time work is it keeps your mind active (…) I found that I've been able to fulfil a large void I had for a period of time, particularly when you're looking at quite a period of time of possibly being destitute, so that can be quite difficult to tackle (…) I enjoy being able to help people here, and the centre for the opportunity they've given me. It's kept me more focused than what I would have been."

Many clients attribute the positive changes they have experienced to the quality of support and attention they receive from centre staff. This theme runs throughout the free text comments in the surveys, and the in-depth interviews:

"Thanks to the staff here, if it wasn't without the staff here, I would be in big trouble, and I'm not exaggerating here."

"They're not judgmental. That's another thing I like about the centre. They don't judge you for what you may have done in the past or anything. As long as you behave yourself here and stuff like that, you're pretty cool."

"I feel that they really seem to understand what I'm going through when I talk about my problems and it seems like some of the workers I had, just to me, they seem like they're really listening (…) They just sit down and really take the time to listen to me, you know?"

"I would say that [the centre] has tried to help me make changes for a long time, I was always anti that cause I wasn't ready. Now this time around I am ready, I'm at that time in my life when I've realised, you know, no bullshit (…) They are supporting me in every endeavor that I have, every goal that I have, to get well, to get drug-free, well, that's another service that I access here as well, is the AOD (Alcohol and Other Drugs). Most importantly though, an acceptance. For the first time in my life I actually believe that the worker cares and wants my life to change as well, and that's so incredibly vital."

"They're just so friendly, you know? They're different to other places where I've been. They've got more time for you. They sit down, they relax with you, they talk to you. Other places, they're sitting in an office, doing their work, you know? They don't have time for the client."

There are also indirect health benefits for clients wherein the centres appear to have protective or preventative effects. 67% of survey respondents say that going to the centre gives them "something to do" (see Fig. 37), which at first glance may not seem an obvious cause for better health. But for those with mental health issues – which comprise half the sample, with depression and anxiety the most common conditions – keeping occupied in the company of others has considerable protective health benefits. One interviewee said of being socially isolated:

> *"You wake up at a set time, and you do these three things that you've got to do, and then you've got a whole day to fill in. That can get people who suffer a little bit from depression or anxiety ... it can really get them in a bad space."*

The same applies for those with chronic health conditions, which again comprises half the sample. Additionally, the in-depth interviews show that having something to do, and somewhere to go, helps attendees reduce their alcohol or drug use, and more generally to stay out of trouble. In the following examples, clients discuss how their lives may be different without the centres:

> *"Without places like this, people, crime will just get worse because people have got nothing to do, nowhere to go, no-one to help them. If these places are open and have got the funding to stay open, if people have got a place to come, catch up, have a cup of coffee, have a meal, and maybe play a game of pool, read a book, use the computers, whatever. They've got something to do rather than sit down on the street and cause trouble all day and that (…) If they didn't exist at all, gee, I suppose I'd have to go into a life of crime and spend time in jail. Especially if I didn't have a job (…) Not that I want to go out and commit crime, the dole's not enough to live on."*

> *"If this place didn't exist and other places didn't exist like this, I'd probably just be walking around. I reckon I'd probably be more depressed. I reckon I probably would have been relapsed and probably my sisters would have tried to get me on medication and whatever else. I would have been worse."*

> *"I'd be a very lonely person. I probably would be dead. I probably would be dead."*

> *"It's not just the meal that they provide but the staff are good you know, if you got a problem they'll talk to you they'll sort it out, they're very helpful. Without these places, well there'd be more people walking around the streets sick. You know, like way out there, they're vulnerable so people will attack them because they don't understand why they talk to themselves or they're, you know yelling out or whatever, they don't understand so without these places, these places are vital."*

Housing

Just under half of the survey sample live in what could be deemed stable long-term housing: 32% of interviewees live in public housing, 9% in private rental, 2% in their own homes and 2% in supported residential services (see Fig. 15). Some, but not all, community rooming houses (occupied by 16% of the sample) could also be considered stable long-term accommodation.

However, as Figure 22 shows, only 20% of the sample have never experienced homelessness: 32% were homeless at the time of interview and a further 48% had experienced homelessness in the past. This indicates that many now stably housed clients have transitioned from homelessness into permanent accommodation.

The survey data shows that in the 12 months prior to interview, 175 respondents – 35% of the entire sample – accessed housing services, with more than half either using the centres' own services or using the centres to access external services (see Fig. 39). 18% of the sample say they now have a better and/or safer place to live as a result of attending the centres (Fig. 44). According to in-depth interviewees, the centres play an important role in this transition:

> *"It has helped my housing situation. I came in here over a year ago, and one of the workers pulled me into the office, and he said, 'Sit down, we're going to fill in an application for you,' something that I would never have done. We filled out an application together, he got me taken up, booked in. He also got me into Yarra Housing, which I appreciated very much. Without these places, things like that, I wouldn't have even thought of. I knew about Yarra Housing for years, but I'd never thought that I could get one. I'd never tried, until he dragged me into the office."*

> *"At the moment my number one is a house. They are helping me with that because once I've got the house I've got every service, they are now ready and I'm having integrated appointments with them because I can't do too much at once without the house. Also sleeping vulnerably as well, I've got to be in the right headspace, so once I've got a house and I have that safety I can go full steam ahead. At the moment we're taking little steps."*

> *"Getting a home was the main thing that helped me, too, because as soon as I got a home I felt more stable in life to help me some more which was good. Once you've got a home you're able to sort of get your life back, you need somewhere to live, because if you don't got nowhere to live things just don't seem to get put into place. It's really hard (…) I've got lots of motivation. I didn't before but now I have."*

Beyond the direct assistance that centres provide in obtaining suitable permanent accommodation, they also support clients to maintain their tenancies. This support is acknowledged directly by 15% of the survey sample (see Fig. 44). There are further indicators of indirect support, such as resolving debt (11%), managing money better (17%), and better managing emotional and mental health (55%), as noted earlier.

But securing suitable housing is only part of the solution for homelessness: maintaining stable accommodation requires life skills that require practice.

Life skills

Not all centre clients need to develop or practice life skills. Many already manage their lives well and come to the centre for social contact, meals, group programs and services. But for others, who have experienced chronic homelessness, debilitating mental illness or other causes for significant social isolation, the centres provide opportunities for learning or re-learning and practicing the skills required in the day-to-day business of living. For people experiencing multiple health or financial issues or personal crises, these can be complex and demanding:

> *"Now I can save, my thoughts are stable enough to do that (…) I've learned now that I don't need this place. I've learned I can go home and actually cook my own lunch now and learned that I can be home and do these things, and I've learned to depend on myself and try not to depend on it anymore and do it for myself now, which is good."*

34% of survey respondents said that attending the centres helped them to learn new skills for getting through life (Fig. 44). Some of these skills are developed through services and programs directly targeting life management, such as financial counselling and legal aid, nutrition programs, mental health groups and cooking classes. Other programs develop the complex social skills required to operate effectively in society through participation in social roles. Such programs include: volunteering at the centre they attend (12%), volunteering elsewhere (13%), participating in sports programs at their centre or elsewhere (16% and 11% respectively), and planned activity groups, which 39% of the sample attend, mostly at their centres (see Fig. 43).

More broadly, the centres function as monitored social environments where people must interact and behave within certain boundaries. This was evident in the observation sessions: at one centre the security guard said he has had to intervene a number of times to prevent clients from fighting on the grounds; and at another there were two observed instances of angry behavior, one where a person dismissed himself from the property after an outburst, and another where a staff member took an abusive person aside to calm him down. Some survey respondents commented appreciatively on how staff monitor and control social interactions, while others said that more needed to be done:

> *"This place is fantastic, the zero tolerance to violence is important to me."*
> *"There have been a few crime outbursts here. They handle them pretty well."*
> *"There are sometimes people gathered out and around the front door who are boisterously consuming alcohol which makes me feel unsafe in regards to entering or leaving the property."*

Staff also have mentoring and modelling roles for social interaction and behaviours. During the observation phase, particularly at Sacred Heart Mission, it was noted that the most interactions transpired between staff and clients, rather than among clients themselves. This was noticed especially at one centre, where the staff position themselves at the centre of the open-plan building so they can observe and be observed continuously; with clients tending to interact with them whenever they move through the centre. The dining room at this centre also provides an instructive example of modelling behavior because it offers restaurant-like service to clients: volunteer staff greet the clients, escort them to their tables, take their orders and serve their meals. The observed effect is that mealtime becomes a convivial and orderly event. This appears to validate the centre's

explicit strategy to initiate and encourage mutual respect at every opportunity. An in-depth interviewee who attends this centre illustrates the benefit of this approach:

> *"I benefit in different ways. I benefit by being a better person to myself, and towards others through them just helping me by getting me clothes and things like that. It makes me feel like a better person, because they've helped me tidy myself up."*

About one-fifth of centre users access services that are aimed directly at gaining employment. 23% of survey respondents are on Newstart (Fig. 10), and 20% used employment services in the 12 months prior to interview, the majority of these being external services. A similar figure of 19% used training and educational services, again most of those externally (Fig. 39). This would suggest that centre clients who are in life situations appropriate for seeking employment are accessing the relevant services.

Unintended Outcomes

No unintended outcomes are indicated directly by the study data. However, one implication may be that some clients are inappropriately dependent on the centres, or that the centres are in some way subsidising their lifestyle choices. Examples of this could be individuals who have been itinerant or homeless for much of their lives, and seem to do this by choice.

One in-depth interviewee appears to fall into this category. He presents himself as a tough, self-sufficient person who doesn't need the company or help of others. He describes himself as a 'traveller' and has accessed centres periodically for decades. Now in his 60s, he is accessing one of the centres on a regular basis, since he feels he is getting too old to be sleeping rough. However, reviewing his life history indicates he grew up in a country marked by violent civil unrest, developed PTSD from three years of active service in the armed forces, and is estranged from his entire family – including his children. Evidently, the impact of this extenuating history and circumstances contributed to his pathway into chronic homelessness. There is no evidence from the discussions with in-depth interviewees – several of whom were or are chronically homeless – that they became or remain homeless by choice.

Nevertheless, one survey respondent did discuss how Open Access services (in providing him with food) allowed him greater choice with his spending elsewhere, even if he made bad choices at times. This may be an unavoidable consequence of utilising meals as a tool for meaningful engagement.

A second issue is that clients may have not reported unintended consequences because their norms around acceptable behaviour differ from the rest of society. For example, workers at the Open Access centres felt that clients may in some cases be desensitised to safety issues because of past trauma. For example, individuals who are frequently exposed to violent actions have the potential to discount verbal abuse as problematic behavior.

Finally, workers at the centres tend to assess clients' suitability for the environment and refer on those who might not 'fit in' or who may have other issues impacting on their suitability (e.g. children). This selection process may minimise unintended consequences.

Challenges for the centres

Gender equity in service usage

Although the centres have taken measures to create safer and more appealing environments for women – Sacred Heart Mission and St Mary's House of Welcome in particular – the female participation rates remain low overall. Survey respondents commented that there should be more female support workers, and more women-only groups, activities, quiet rooms and venues.

Insufficient resourcing to meet demand

According to clients, the centres are not resourced enough to meet demand. Figure 22 shows that 21% of surveyed clients said there was at least one occasion in the previous four weeks when they had not been able to access a centre service when they needed it. The most common reasons for non-access clients gave were insufficient staffing, no vacant appointments, lack of facilities or lack of funding for the service, and the centre being closed on weekends or public holidays. This resonates with reports in the literature that funding and resourcing are the primary challenges for Open Access centres.

Survey respondents and in-depth interviewees made a number of suggestions for improving or expanding services, while acknowledging that their centres would need more funding to make the following requests possible:

1. **Requests specific to identity sub-groups:**

- More women's services and facilities, as noted above
- Aboriginal case workers
- Men's discussion groups

2. **Centre practicalities/services:**

- Longer opening hours, including weekend openings (only one of the centres is open on weekends)
- More outings and excursions including galleries, movies and theatre
- Larger meal sizes; more meal choices for people with diabetes, dieting or with allergies.
- More group activities such as music, cooking, arts and crafts, and singing
- More recreational and fitness programs, and outdoor activities
- More computers; Wi-Fi access; IT education
- A quiet room; less noisy environments
- More language-proficient workers for non-English-speaking clients
- Education sessions on hygiene
- More support programs on conflict management
- More up-to-date and broader range of information leaflets on services
- Better handling of complaints
- More centres, especially in outer suburbs and more remote areas
- More financial assistance
- More/longer/more frequent case management services

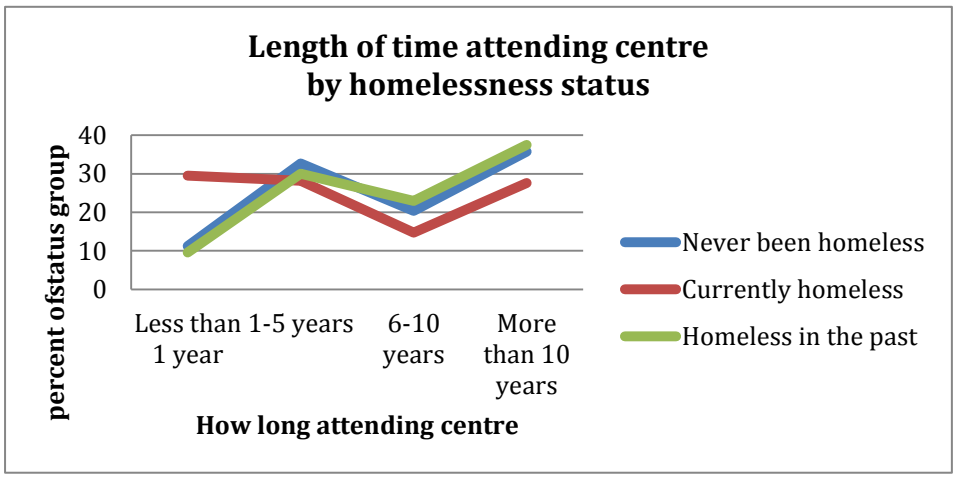
- More security to keep drug users and consumers of alcohol away from centres and entrances
- Provision of safe crisis/temporary accommodation

Sustaining client communities

All the data gathered for this study indicate that the Open Access centres do succeed in breaking cycles of homelessness and helping to resolve episodic crises for clients. The data also indicates, however, longer-term usage by those who would be considered chronically homeless, as well as by individuals who are permanently housed.

In Figure 45 below, the survey sample is split into three groups: those who have never been homeless; those who are currently homeless, and those who have been homeless in the past.

Figure 45: Length of time attending centre by homelessness status



The data trends for all three groups are strikingly similar, with the lines for 'Never been homeless' and 'Homeless in the past' virtually identical. The 'currently homeless' group too is substantially similar, differing only in the higher proportion of new attendees.

This analysis strongly supports information from the in-depth interviews that clients continue to attend the centres even after they gain stable accommodation, and the notion that people experiencing chronic homelessness may also utilise the centres over the longer term.

High levels of centre usage for core health services compared with usage of external services (Fig. 40) shows that the centres are primary access points for clients who cannot or choose not to obtain those services elsewhere. Furthermore, the survey data demonstrate how rarely clients engage with mainstream community activities outside of the Open Access centres (Fig. 43).

When these usage patterns are considered alongside the substantial reported social benefits of attending centres, there is a clear indication that across the client spectrum, the Open Access centres are foci for community creation. They help to create and sustain community for people who, irrespective of their housing situation, are effectively excluded from finding community elsewhere. In addition, they provide much-needed services for their clients in one convenient location. In this sense, Open Access centres function as *multi-purpose community centres* for those experiencing

significant socioeconomic marginalisation and homelessness. The challenge for the Open Access centres is how to continue to maintain their dual-purpose model that, on the one hand, integrates long-term care, providing both a one-stop shop for servicing client needs; and on the other, supports clients in living to their full potential, encourages capacity building and enables clients to graduate from the system altogether.

Conclusions and Recommendations

This study broadly supports the literature review findings that Open Access centres provide vital services to homeless and marginalised individuals. They play an important role in mitigating and insulating clients from many of the daily challenges of homelessness and poverty in a location that is physically, socially and emotionally safe.

Effectiveness of the centres in this study

Engagement with services internal and external

The survey and interview material demonstrate that the majority of clients are well engaged with services relevant to their needs. It should be noted that service engagement is not necessarily automatic or immediate for people who are unwell or experiencing extreme social isolation: rather it is contingent on the development of rapport and trust between clients and workers, and with the centre as a whole. In addition, an individual's personal circumstances (including their experience of personal/organisational/systemic issues) will determine whether they will engage with the opportunities afforded to them by the Open Access system, and secondly, take advantage of them to the point they can graduate from the services.

The survey and interviews also suggest that many clients look to Open Access centres to be a 'one-stop shop' for their service needs where possible. The in-depth interviews indicate that this is less a choice of convenience and more one of necessity, for reasons of poverty and feeling unwelcome in mainstream society.

These two factors – the issue of trust and the feeling of unease resulting from discrimination experienced at mainstream services – may help explain the apparently low transfer to mainstream services by many centre clients. Additionally, people who have transferred to mainstream services may no longer be using the centres at all and would not be accessible in this study. Longitudinal study of client populations and/or following up ex-clients would be required to examine transfer from centre-based to mainstream service usage.

Improved quality of life

All the research findings point to improved quality of life in the domains of social inclusion, physical and mental well-being, housing (within the constraints of a severe shortage of affordable housing) and life skills. Improved economic circumstances appear to be unachievable for most clients beyond the savings they can make by using the centres' free or low-cost facilities and services, as the majority are on fixed income disability or age pensions.

Unmet needs and service gaps

Survey data indicates that the demand for support workers, service appointments, programs and activities, opening hours and quiet spaces/women-only facilities exceeds the resourcing capacity of the centres. However, the centres do appear to be meeting the most critical needs of their clients.

Empowerment or dependency?

The common denominator in all clients surveyed or interviewed for this study is poverty. Many clients experience additional social marginalisation by way of illness and/or life events. Moreover, mainstream avenues for finding social acceptance, belonging and community are simply unavailable for many, if not all, centre clients due to cost alone. Open Access centres provide clients with venues where they can be themselves and enjoy meals and activities in the company of others, even if they choose not to engage with them. It should be noted that the centres also make it possible for visiting and co-located agencies to fulfil their mandates to service the most marginalised people in society, by gathering hard-to-reach target group members in the one location. In this sense, Open Access centres have a unique yet integral role in community health, social security and legal systems.

There is sufficient evidence from this study to conclude that all the centres surveyed function as multi-purpose community centres, providing clients with access to community membership and the substantial health and well-being benefits that flow from social inclusion. This undermines the notion of there being a dilemma between empowerment and dependency for Open Access centre clients. Rather, the communities fostered by Open Access centres provide functional benefits for members, just as they do in other communities. Entry opportunities to these other communities are minimal for a high proportion of clients, according to the evidence presented in this report.

Improving service models and client outcomes

Recommendations for improvement drawn from client responses fall into two areas: enhancing clients' social interactions and expanding or improving services and facilities. Both of these strategies can be expected to lead to better client outcomes. There is no evidence from this research that changing the overarching service models would necessarily lead to better client outcomes.

Enhancing social interactions

This domain covers clients' interactions with workers and with other centre users.

The importance of the empathetic quality of interaction between clients and centre workers is well documented in the literature, and reinforced by comments from participants in this study. According to our research, centre workers do very well in this regard on most occasions, and clients are very clear about the positive impact these interactions have on their lives. Conversely, occasions where clients feel they are not listened to or given the time they needed, or when they lose touch with trusted workers due to staff changes, cause temporary or permanent damage to their trust in the entire centre. They can also have negative consequences for clients in terms of their well-being and recovery progress. Open Access centres should continue their vigilance managing these issues. Agencies also need to be very aware of client sensitivity to change, and ensure that clients know that management is listening to their concerns, whether delivered by individual representation or through a client reference group.

Research participants provided several indications of how to improve their experience with other centre users. Centres could consider adopting the following recommendations, based on clients' suggestions and their reports of positive or negative experiences:

- Run conflict management programs for clients, or more frequent programs if already offered
- Increase safety monitoring measures, especially concerning the safety of women and curtailing offensive behaviour immediately outside centre premises
- Encourage respect for women among male clients
- Expand volunteering opportunities for clients, while keeping clear the distinction in authority between staff and volunteer roles
- Make quiet spaces available for when clients need time away from noise and stimulation
- Enhance referral pathways and partnerships with other agencies that provide these services or opportunities

Improving services and facilities

Nearly all recommendations in this category are heavily resource dependent. In approximate order of cost from high to low, these are:

- Renovate or rebuild centres to maximise visibility and safety, and the sense of a pleasant and welcoming environment
- Provide women-only venues/areas and facilities if not already in place
- Offer longer opening hours and weekend opening if not offered already
- Increase the duration and frequency of case management services
- Engage more multilingual and culturally appropriate workers, where relevant
- Provide more outings and excursions that take participants into mainstream venues or activities they could not otherwise attend
- Provide more programs and groups covering cooking, music, art and physical fitness activities
- Increase and update IT facilities for clients and offer regular courses on how to use them

Engaging with policy change

The NDIS is a national approach based on insurance principles that will provide individualised support and services to help those with a disability, their families and carers achieve their goals and aspirations (DHS). The reforms involve the service system transitioning from being a supply-led to a demand-led system, which requires individuals to engage with the system differently and gives them a greater opportunity to influence the service system through the way they contract services (State Trustees, 2016). According to the DHS, “the NDIS represents a significant change in the way in which people with disability will be accessing services, which will change the way in which service providers do business” (DHS, 2016). The reforms serve to place the person concerned at the centre of the service system, creating an insurance model to provide people with a disability (including psychosocial disability) the support and services they need to participate in and contribute to the community (DHS, 2016; State Trustees, 2016). They purport to provide individuals with greater choice and control in their lives, serving to restructure the service system. Significantly, the reforms suggest a shift towards a more competitive, market-based service system, with a move away from block-funded service delivery and towards individual, user-based funding. This implies that current funding arrangements with disability service providers will continue in each area until the transition

has been determined. Over time, however, disability service providers will move from block funding arrangements to individualised funding in arrears of service delivery (DHS, 2016).

According to the Psychiatric Disability Services of Victoria, the launch of the NDIS represents perhaps the most important change to the human service system in Australia since the introduction of Medicare 30 years ago (VICSERV, 2016). According to this organisation, "the change from block funding of support services to individualised disability funding – along with parallel changes to the funding and operations of health, mental health and primary health care sectors being driven by national health reform – presents both great opportunities and potential risks for people living with mental illness" (VICSERV, 2016). Of particular concern for clients is that they may not be adequately supported to understand the revised system (Lester, 2016). It is feared that vulnerable groups may find the system reforms too challenging to engage with and so not access the system, thereby missing out on available support (State Trustees, 2016). In addition, service organisations may not be adequately positioned or supported to work through the practical and cultural changes involved in moving to an individualised, consumer-led funding and service delivery model (State Trustees, 2016).

As such, providers are being forced to consider their approach to service delivery in the context of this reform (DHS, 2016). The exact impact on funding arrangements is, at this stage, opaque. In particular, it is unknown how funding eligibility will be operationalised, and how it will evolve. As such, an ongoing need for community mental health services to be provided outside the NDIS system is likely (VCOSS, 2015). This has created an imperative to better understand the role of Open Access services in providing care to vulnerable populations and how the services should adapt to meet the needs of their clients more effectively.

This study shows that Open Access centres have a high proportion of potentially eligible clients who are currently on Disability Pensions and have complex needs. It also demonstrates that Open Access centres are important in keeping these clients in their own homes. It is also clear that Open Access services constitute hubs where integrated care, particularly allied and mental health care, are provided. Open Access services are well positioned to provide integrated care to a client group with very complex needs. Ensuring that this expertise is recognised, and that Open Access services are included as part of the development of plans, is a key area for advocacy. This position may strengthen because it is anticipated that some local councils will cease to provide home and community care as the Australian Government takes over responsibility for this among the over 65s, and the NDIS is operationalised for the under 65s (DHHS, 2016). This will create a service gap that Open Access services are well positioned to fill.

The precise eligibility and service provision associated with some of these reforms, particularly the NDIS, are currently unknown. Table 17 outlines the steps in delivering the ideal program, the gaps that might arise at each stage and potential responses of Open Access services in order to ensure the needs of all clients are met. How these responses should be prioritised will depend both on the proportion of eligible clients and what service delivery is funded for them. This will also have flow-on effects for services that will need to be funded from sources other than schemes such as the NDIS. Those who are ineligible for the NDIS will also require greater advocacy to achieve access and support from other systems (VCOSS 2016). This puts further strain on the system, as funding for disability advocacy is woefully inadequate, resulting in large gaps in geographical coverage and types of advocacy (VCOSS 2016).

Table 17: Ideal program delivery, service gaps and responses

Ideal NDIS program	Gaps at each stage	Open Access service response
Clients apply to participate		Potentially eligible clients supported to apply
Clients eligible	Clients ineligible	Alternative services/support found for ineligible clients
Clients NDIS Plan established	Clients not able to engage in plan development	Clients supported to develop plan best suited to their needs Advocacy to ensure that plans include all services clients need
Plan addresses clients' needs	Plan does not meet clients' needs	Plans reviewed to assess the extent to which the needs of Open Access clients are supported Advocacy to ensure that plans include all services clients need
Required services delivered at reasonable cost	Services not delivered, poor quality or too expensive.	Evaluation of services delivered to ensure that quantity, quality and cost are appropriate Advocacy to ensure that plans are appropriate and that services are delivered
Better outcomes		

Recommendations

Recognising the value of Open Access services

This study has recognised the strengths and benefits of Open Access centres, and their role in preventing adverse outcomes for clients with complex needs and disadvantages. It found very little evidence of unintended negative consequences. Policy change on a number of fronts could impact on Open Access services and their clients. In this context, the value of Open Access services needs to continue to be recognised. The Open Access model of service itself should be promoted, highlighting its unique approach for members of society who are experiencing, or at risk of, homelessness. The fact that these spaces allow people access to meals, essential services and a place to belong without requiring anything of the client, including personal information, is a key feature of their service delivery.

Enhancing clients' social interactions and expanding or improving services and facilities

Recommendations for service and centre improvements fall into two categories: enhancing clients' social interactions, and expanding/improving services and facilities. To address the fact that many individuals within the sampled population experience social isolation, it is important to facilitate interactions among clients as well as with staff members. Continuing to encourage participation in activities and creating an environment conducive to social interaction is key to this. In addition, further incorporating client feedback into the improvement of services and facilities will continue to improve client satisfaction. These strategies can be expected to lead to better client outcomes. There is no evidence from this research that changing the overarching service models would necessarily lead to better client outcomes.

Developing systematic approaches to reducing safety threats

During the consultation phase of the project, workers at the Open Access centres identified a number of programmatic proposals (e.g. changing meal times) and client management proposals (e.g. screening and assessing attendee vulnerability) to help reduce potential safety issues. While extensive safety procedures exist at Open Access centres, the strategies used by centre staff to manage minor risks and incidents are seldom reported, including communication of these procedures between centres. A more systematic approach to documenting these strategies may be helpful in understanding their effectiveness and adjusting to changing client populations.

Promoting the role of Open Access centres in providing integrated care

The study showed that Open Access centres are seen as a 'one-stop shop' to meet their clients' needs. They provide a broad range of health – including allied health –and social services. Current reforms associated with the National Disability Insurance Scheme, aged care and mental health focus on the provision of integrated care. Open Access service leadership in this area should be highlighted, particularly for clients with complex needs. Therefore, it is important that the system be recognised as serving a dual purpose within the community:

1) Open Access services are leaders in integrated care, providing a one-stop shop for servicing client needs;
2) Open Access services support clients in reaching their full potential, encourage capacity building and enable clients to graduate from the system altogether.

Engaging with policy change

The National Disability Insurance Scheme (NDIS) aims to provide integrated care for people with disabilities under the age of 65, and encompasses reforms in aged care and mental health. Among clients in this demographic, 61% were on Disability Pensions. Of these, 10% reported a physical illness, 29% a mental illness and 40% both a mental and physical illness. These figures were 9.9%, 25.2% and 23.8% respectively for clients under the age of 65 who were not in receipt of a Disability Pension. This may suggest there are eligible clients who are currently not receiving benefits. Given the outcomes framework underpinning the NDIS, it would also be recommended that Open Access centres continue the process of developing their own outcomes frameworks and measure their impact on clients in order to be aligned with the policy changes.

Open Access centres need to ensure that all eligible clients are accessing new schemes and that these schemes are included as part of a client's care. It is also important to ensure that funding is not eroded to the extent that eligible clients are no longer able to receive care.

Client eligibility and funding implications associated with the NDIS are still unknown. However, consultation with Open Access centres in pilot sites may provide important insights, in order to better inform responses.

Works Cited

Bantchevska, D., Erdem, G., Patton, R., Linley, J., Letcher, A., Bonomi, A., and Slesnick, N. (2011). Predictors of Drop-in Center Attendance among Substance-Abusing Homeless Adolescents. *Social Work Research, 35*(1), 58-63.

Biederman, D. J., Nichols, T. R., and Lindsey, E. W. (2013). Homeless Women's Experiences of Social Support from Service Providers. *Journal of Public Mental Health, 12*(3), 136-145

Booth, R. E., Zhang, Y., and Kwiatkowski, C. F. (1999). The Challenge of Changing Drug and Sex Risk Behaviors of Runaway and Homeless Adolescents. *Child Abuse and Neglect, 23*(12), 1295-1306.

Butler, S. S., and Weatherley, R. A. (1995). Pathways to Homelessness among Middle-Aged Women. *Women and Politics, 15*(3), 1-22.

Crammond, R., Shewprassad, S., and Boston, T. (2006). *Drop-in Services Sector: Literature Review of Good Practices*. Retrieved from: https://www1.toronto.ca/city_of_toronto/shelter_support__housing_administration/files/pdf/drop-in-literature-review-060710.pdf

Cunningham, C. O., Sanchez, J. P., Heller, D. I., and Sohler, N. L. (2007). Assessment of a Medical Outreach Program to Improve Access to HIV Care Among Marginalized Individuals. *American Journal of Public Health, 97*(10), 1758-1761.

De Rosa, C., S., M., M., K., Iverson, E., Ma, J., and Unger, J. (1999). Service Utilization among Homeless and Runaway Youth in Los Angeles, California: Rates and Reasons. Journal of Adolescent Health, 24(6), 449-458.

DHHS. (2016). Victoria's HACC system in transition. Retrieved from: https://www2.health.vic.gov.au/ageing-and-aged-care/home-and-community-care/hacc-transition

DHS. (2016). The National Disability Insurance Scheme. Projects and Initiatives. Retrieved from: http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/projects-and-initiatives/disability-services/national-disability-insurance-scheme

Dasari, M., Borrero, S., Akers, A. Y., Sucato, G. S., Dick, R., Hicks, A., and Miller, E. (2016). Barriers to Long-Acting Reversible Contraceptive Uptake Among Homeless Young Women. *Journal of Pediatric and Adolescent Gynecology, 29*(2), 104-110.

Esparza, N. (2009). Community Factors Influencing the Prevalence of Homeless Youth Services. *Children and Youth Services Review, 31*(12), 1321-1329.

Evans, N. S., and Dowler, E. A. (1999). Food, Health and Eating among Single Homeless and Marginalized People in London. *Journal of Human Nutrition and Dietetics, 12*(3), 179-199

Fitzpatrick-Lewis, D., Ganann, R., Krishnaratne, S., Ciliska, D., Kouyoumdjian, F., & Hwang, S. W. (2011). Effectiveness of Interventions to Improve the Health and Housing Status of Homeless People: A Rapid Systematic Review. *BMC Public Health, 11*.

Garrett, S. B., Higa, D. H., Phares, M. M., Peterson, P. L., Wells, E. A., & Baer, J. S. (2008). Homeless Youths' Perceptions of Services and Transitions to Stable Housing.

Goering, P., Durbin, J., Trainor, J., & Paduchak, D. (1990). Developing Housing for the Homeless. *Psychosocial Rehabilitation Journal, 13*(4), 33-42.

Grella, C. (1994). Contrasting a Shelter and Day Center for Homeless Mentally Ill Women: Four Patterns of Service Use. *Community Mental Health Journal, 30*(1), 3-16.

Healthcare, H. (2016). Homeless Healthcare. Retrieved from: http://homelesshealthcare.org.au/?page_id=18

Hendry, D. G., Woelfer, J. P., Harper, R., Bauer, T., Fitzer, B., and Champagne, M. (2011). How to Integrate Digital Media into a Drop-in for Homeless Young People for Deepening Relationships between Youth and Adults. *Children and Youth Services Review, 33*(5), 774-782.

Heyding, R. K., Cheung, A. M., Mocarski, E. J. M., Moineddin, R., and Hwang, S. W. (2005). A Community-based Intervention to Increase Screening Mammography among Disadvantaged Women at an Inner-city Drop-in Center. *Women and Health, 41*(1), 21-31

Johnsen, S., Cloke, P., and May, J. (2005). Day Centres for Homeless People: Spaces of Care or Fear? *Social and Cultural Geography, 6*(6), 787-811.

Lester, K. (2016). Psychosocial Disability Definition Causes Confusion among NDIS Applicants. Retrieved from: http://www.abc.net.au/news/2016-04-18/ndis-confuses-applicants-with-psychosocial-definition/7334114

Magee, C., and Huriaux, E. (2008). Ladies' Night: Evaluating a Drop-in Programme for Homeless and Marginally Housed Women in San Francisco's Mission District. *International Journal of Drug Policy*, 19(2), 113-121.

Martino, S., Tucker, J., Ryan, G., Wenzel, S., Golinelli, D., and Munjas, B. (2011). Increased Substance Use and Risky Sexual Behavior Among Migratory Homeless Youth: Exploring the Role of Social Network Composition. *Journal of Youth and Adolescence, 40*(12), 1634-1648.

McBride, T. D., Cokyn, R. J., Morse, G. A., klinkenberg, W. D., and Allen, G. A. (1998). Duration of Homeless Spells among Severely Mentally Ill Individuals: A survival analysis. *Journal of Community Psychology, 26*(5), 473-490.

McCay, E., Carter, C., Aiello, A., Quesnel, S., Langley, J., Hwang, S., . . . Karabanow, J. (2015). Dialectical Behavior Therapy as a Catalyst for Change in Street-involved Youth: A Mixed Methods Study. *Children and Youth Services Review, 58*, 187-199.

Meagher, S. (2008). *Measuring Success: Show What We Know Evaluation Strategies for Drop-In Settings*. Retrieved from: https://www1.toronto.ca/city_of_toronto/shelter_support__housing_administration/files/pdf/measuringsuccessapril7.pdf

Morse, G. A., Calsyn, R. J., Allen, G., Tempelhoff, B., and Smith, R. (1992). Experimental Comparison of the Effects of 3 Treatment Programs for Homeless Mentally Ill People. *Hospital and Community Psychiatry, 43*(10), 1005-1010.

Nelson, S., Gray, H., Maurice, I., and Shaffer, H. (2012). Moving Ahead: Evaluation of a Work-Skills Training Program for Homeless Adults. *Community Mental Health Journal, 48*(6), 711-722.

Norton, B. L., Voils, C. I., Timberlake, S. H., Hecker, E. J., Goswami, N. D., Huffman, K. M., . . . Stout, J. E. (2014). Community-based HCV Screening: Knowledge and Attitudes in a High Risk Urban Population. *BMC Infectious Diseases, 14*(1), 1-17.

Pollio, D. E., Spitznagel, E. L., North, C. S., Thompson, S., and Foster, D. A. (2000). Service Use Over Time and Achievement of Stable Housing in a Mentally Ill Homeless Population. *Psychiatric Services, 51*(12), 1536-1543.

Slesnick, N., Dashora, P., Letcher, A., Erdem, G., and Serovich, J. (2009). A Review of Services and Interventions for Runaway and Homeless Youth: Moving Forward. *Children and Youth Services Review, 31*(7), 732-742.

Slesnick, N., Feng, X., Guo, X., Brakenhoff, B., Carmona, J., Murnan, A., . . . McRee, A.-L. (2016). A Test of Outreach and Drop-in Linkage Versus Shelter Linkage for Connecting Homeless Youth to Services. *Prevention Science*, 1-11.

Slesnick, N., Glassman, M., Garren, R., Toviessi, P., Bantschevska, D., and Dashora, P. (2008). How to Open and Sustain a Drop-in Center for Homeless Youth. *Children and Youth Services Review, 30*(7), 727-734.

Slesnick, N., Kang, M. J., Bonomi, A., and Prestopnik, J. (2008). Six- and Twelve-Month Outcomes among Homeless Youth Accessing Therapy and Case Management Services through an Urban Drop-in Center. *Health Services Research, 43*(1), 211-229.

Slesnick, N., Glassman, M., Garren, R., Toviessi, P., Bantchevska, D., and Pushpanjali, D. (2007). How to Open and Sustain a Drop-in Center for Homeless Youth. *Children and Youth Services Review*, *30*(7), 727-734.

Sosin, M., George, C., and Grossman, S. (2012). Service Content as a Determinant of Homeless Adults' Perceptions of Program Efficacy. *Journal of Community Psychology, 40*(2), 249-263.

State Trustees, A. F. (2016, 13 April 2016). Understanding the Impact of Recent Government Reforms in the Disability, Ageing and Mental Health Sectors. Paper presented at the Ageing, Disability and Mental Health Collaborative Panel, Melbourne.

Story, A., Aldridge, R. W., Gray, T., Burridge, S., and Hayward, A. C. (2014). Influenza Vaccination, Inverse Care and Homelessness: Cross-sectional Survey of Eligibility and Uptake During the 2011/12 Season in London. *BMC Public Health, 14*(1), 1-15.

Tarasuk, V., Dachner, N., and Li, J. G. (2005). Homeless Youth in Toronto are Nutritionally Vulnerable. *Journal of Nutrition, 135*(8), 1926-1933.

Thompson, S., McManus, H., Lantry, J., Windsor, L., and Flynn, P. (2006). Insights from the Street: Perceptions of Services and Providers by Homeless Young Adults. *Evaluation and Program Planning, 29*(1), 34-43.

Tsemberis, S., Moran, L., Shinn, M., Asmussen, S., and Shern, D. (2003). Consumer Preference Programs for Individuals Who are Homeless and Have Psychiatric Disabilities: A Drop-In Centre and a Supported Housing Program. *American Journal of Community Psychology, 32*(3-4), 305-317.

Tucker, J. S., Hu, J., Golinelli, D., Kennedy, D. P., Green, H. D., and Wenzel, S. L. (2012). Social Network and Individual Correlates of Sexual Risk Behavior Among Homeless Young Men Who Have Sex With Men. *Journal of Adolescent Health, 51*(4), 386-392.

VCOSS. (2015). Ensure Community Mental Health Services Can Continue Supporting People as the NDIS is Rolled Out. VCOSS Voice. Retrieved from: http://vcoss.org.au/blog/ensure-community-mental-health-services-can-continue-supporting-people-as-the-ndis-is-rolled-out/

VCOSS. (2016). The NDIS Isn't Enough. We need Strong Disability Advocacy Too. VCOSS Voice. Retrieved from: http://vcoss.org.au/blog/disability-advocacy/

VICSERV. (2016). National Disability Insurance Scheme. National Issues. Retrieved from: http://www.vicserv.org.au/national-issues/national-disability-insurance-scheme

Wenger, L. D., Leadbetter, J., Guzman, L., and Kral, A. (2007). The Making of a Resource Center for Homeless People in San Francisco's Mission District: A Community Collaboration. *Health and Social Work, 32*(4), 309-314.

Winetrobe, H., Rhoades, H., Barman-Adhikari, A., Cederbaum, J., Rice, E., and Milburn, N. (2013). Pregnancy Attitudes, Contraceptive Service Utilization, and Other Factors Associated with Los Angeles Homeless Youths' Use of Effective Contraception and Withdrawal. *Journal of Pediatric and Adolescent Gynecology, 26*(6), 314-322.

Xiang, X. L. (2013). A Review of Interventions for Substance Use Among Homeless Youth. *Research on Social Work Practice, 23*(1), 34-45.

Zerger, S. (2002). Substance Abuse Treatment: What Works For Homeless People? A Review of the Literature. Retrieved from: http://www.nhchc.org/wp-content/uploads/2012/02/SubstanceAbuseTreatmentLitReview.pdf

Appendix 1

Interview schedule

Thank you for taking the time to help us by agreeing to do this interview. In this interview I would like to understand a little bit more about you, the services you use and how they can be better designed to meet your needs.

So first I'd like to start out by asking:

Understanding their history of coming to the centre

- How long have you been coming to this centre?
- What brought you to the centre in the first place? What was happening in your life then?
- [Probe gently for their back history, as far as your rapport allows at this moment. Be alert to what the interviewee says as cues to delve further. By the end of the interview you should cover: current and past housing; family situation past and present, important others in their life, income and employment challenges]

Centre usage now

- What brings you to the centre now? What do you do when you come here?
- How frequently do you come to the centre? When do you tend to come? (Why do you keep coming back?)
- What would you say you get out of coming to the centre?
- What services here do you use?
- What other services or drop-in centres do you use? How did you connect with these?
- Are there any services you need but you can't access?
- How do you feel you benefit from the services?

Health and other issues

- Do you have any health issues that make life harder or stop you from doing things you want to do or need to do?
- Are there any other problems that make life harder for you?
- Are you getting enough help with these issues? What other help would make life better?
- Has your health improved as a result of coming to these drop-in centres? How would your health be different if you didn't have access to these centres?
- Do you feel the centre is a safe space for you to attend?
- Have your needs been addressed in attending the centre/centre programs?

Making changes

- Where would you go if you didn't come to this centre? Where would you go if drop-in programs didn't exist?
- Do you think drop-in services are important? Why?
- Would you say that coming here has helped you make positive changes in your life/your health/your housing situation?
- [If yes] What changed? How did that happen?
- Are there any changes in your life that you'd like to see happen? What would it take to make those changes happen?
- Where would you like to see yourself one year from now?
- Do you think this centre could play a part in helping that to happen?

Comments about the drop-in centre

- What do you like most about this centre?
- Is there anything you don't like?
- Have you noticed anything that could be improved?

Housing present and past

- So what is your housing situation at the moment? What sort of place are you living in? [Probe: is that with family or friends or...?]
- Do you want to stay or move? How long have you been there? And before then?

Income and employment

- Now I want to ask about your financial situation, if that's OK. What is your main source of income? Is that enough to make ends meet? How do you get by if it isn't?
- [If not working now] When was the last time you were able to get paid work? What are the barriers to you getting work?

Relationships

- Do you have any family in Melbourne? [probe if still in contact with family wherever they are; probe to ask about growing up]
- Who do you interact with on a daily/weekly basis (generally and at the centre)?

Final Q

- Is there anything we haven't talked about that we should know, or you want to tell us?

…….

Thank you for your time.

Appendix 2

Drop-in Client Survey Version 5.3

Administrative section

1. Name of drop-in centre

2. Administrative data

Sequential Number		Interviewer Name	
Date of Survey	/ /		
Type of consent Written (W) or Oral (O)		Interviewee identifiers 2 letters first and last name	

Confidential Survey of People Who Use Drop-in Services

"In this survey we ask you questions to help us understand who is using the drop-in service, what their needs are and whether the services provided are meeting those needs.

"In the first half of this survey I would like to gather some information about you, your housing situation and your health."

3. What suburb or area do you currently live in? ……

4. How old are you?
   □ *Under 18* □ *18-24* □ *25-44* □ *45-64* □ *65 or over.*

5. What is your gender?
   □ Male □ Female □ Other……

6. Where were you born?
   □ Australia □ Other (please specify)……

7. Are you of Aboriginal or Torres Strait Islander origin?
   □ Neither □ Aboriginal □ Torres Strait Islander □ Both Aboriginal and Torres Strait Isl.

8. Is English your main language? □ Yes □ No

9. If you answered 'No' to Q8, what is your main language? ……

10. What is your education level?

□ Primary school □ Secondary / High school □ Trade or Technical Qualification/TAFE
□ University degree or equivalent □ Don't know

11. What best describes your current living arrangements? Are you…. (please tick ONE only)
□ Living alone □ Living with your partner / family members / people you feel close to
□ Living with others

12. Do you care for any dependent persons? □ Yes □ No

13. If you answered 'Yes' to Q12, how many dependents do you care for?
Children …… Adults ……

14. What are your sources of income? (Tick all that apply):
□ No income □ Own Wage □ Spouse / partner's income □ Centrelink

□ DVA Pension □ Other (please specify)……

15. If you are receiving Centrelink payment, which ones are they?
□ Newstart □ Disability Pension (DSP) □ Age Pension
□ Austudy □ Abstudy
□ Don't know □ Other (please specify)……

16. Are you currently looking for work?
□ Yes □ No

17. If you answered 'Yes' to Q16, what methods are you using to find work? Please tick all that apply
□ Employment services □ Jobseeking websites □ Word of mouth
□ Other (please specify)……..

18. During the past six months have debts got in the way of meeting your basic needs, such as buying food, paying for transport, accommodation or other bills?
□ Yes – often □ Yes – sometimes □ No

19. Which of these best describes your current accommodation? Please tick ONE of the following:
□ Private rooming house – shared facilities □ Private rooming house – self-contained
□ Public housing – long term □ Sleeping rough, e.g. squat, street, car
□ Private rental □ Supported Residential Service
□ Community rooming house – shared facilities □ Community rooming house – self contained
□ Staying with friends/couchsurfing □ Crisis Accommodation
□ Caravan park □ Own home
□ THM – Transitional Housing □ YWCA Hostel □ Other:…….

20. For how long have you been living at this accommodation? ……

21. Do you feel safe where you currently live?
□ No □ Yes moderately safe □ Yes very safe

22. Are the services and facilities that you need easy to get to from where you currently live?
    □ No □ Yes moderately easy □ Yes very easy

23. Are you able to connect with friends and family from where you currently live?
    □ No □ Yes sometimes □ Yes often

24. Do you feel part of your local community where you currently live?
    □ No □ Yes moderately □ Yes very much

25. Can you provide an estimate of how many times you have shifted accommodation….

    a. In the last six months?
       Not at all; 1-5 times; 6-10 times; 11-20 times; 21-30 times; more than 30 times

    b. In the last five years?
       Not at all; 1-5 times; 6-10 times; 11-20 times; 21-30 times; more than 30 times

Interviewer: We define homelessness as: People without conventional accommodation (living on the streets or in squats etc); people staying temporarily with other households (because they have no usual address); people in emergency accommodation (refuges, shelters etc); and people living temporarily in boarding houses or caravan parks.

26. Are you now or have you ever been homeless?
    □ Yes currently □ Yes in the past □ No

27. If you answered 'Yes currently' to Q26, how long has it been since you were living in permanent accommodation, say for more than two years in the same place?
    □ Less than a week
    □ 1 to 4 weeks
    □ 1 to 6 months
    □ 6 months to 1 year
    □ 1 to 5 years
    □ More than 5 years

28. During the past four weeks has your mental health stopped you from doing what you wanted to do or need to do, e.g. go to an appointment?
    □ Yes often □ Yes sometimes □ No

29. Do you regard yourself as living with a mental health condition or mental illness of any type?
    □ Yes □ No

30. If you answered 'Yes' to Q29, what is the condition or illness? **……..**

31. During the past four weeks has your physical health stopped you from doing what you wanted to do or needed to do, e.g. climbing stairs, preparing a meal, day-to-day tasks?
    □ Yes often □ Yes sometimes □ No

32. Do you regard yourself as living with chronic disease or chronic illness?
    □ Yes □ No

33. If you answered 'Yes' to Q32, what is the disease or illness? **……..**

34. Are you able to see a doctor when you need to?
    □ Yes □ No but I would like to see one whenever I need to □ No I'm not interested

35. During the past four weeks has alcohol or drug use stopped you from doing what you wanted to do or needed to do e.g. getting a meal, attending a program or appointment, going to work?
    □ Yes often □ Yes sometimes □ No

36. If you needed to talk to someone about a serious issue, who would you talk to? Please tick one or more of the following:
    □ Friend □ Family member □ Case manager/Social worker □ Don't know
    □ I would not talk to anyone □ Religious person e.g. priest, nun
    □ Counsellor or health professional □ Other …….

"Now, in the second half of the survey, I would like to ask about your use of this drop-in centre"

37. For how long have you been attending this drop-in centre?
    □ Less than 1 year
    □ 1-5 years
    □ 6-10 years
    □ More than 10 years

38. How often do you attend this drop-in centre?
    □ Daily
    □ 2 or 3 times a week
    □ Weekly
    □ Fortnightly
    □ Monthly
    □ Occasionally

39. Do you also go to other drop-in centres such as the Indian Sisters, or St Peter's or St Mark's?
    □ Yes □ No

40. If you answered 'Yes' to Q39, how often do you attend other drop-in centres? **……..**

41. Which of the following reasons best describe why you use this drop-in centre? Please tick all that apply.

    □ I'm homeless and need assistance to access housing
    □ My housing is at immediate risk e.g. eviction
    □ I am fleeing a family violence situation
    □ To access women's services
    □ I need support to remain living in my own home
    □ I've moved into one of this agency's residential services
    □ Assistance with physical health issues
    □ Assistance with mental health issues

- □ Assistance with alcohol or other drug issues
- □ To access a group or volunteer program
- □ For social connection, seeing people, meeting friends
- □ For material and/or financial assistance or support
- □ For meals
- □ To use the facilities e.g. showers, laundry, computers and internet, phone charger
- □ Referral to another service
- □ Other (please specify) …….

42. Is this drop-in centre a place where you feel accepted by others?
    - □ Yes
    - □ No
    - □ Unsure
    - □ Not applicable

43. Is this drop-in centre a place where you feel safe?
    - □ Yes
    - □ No
    - □ Unsure
    - □ Not applicable

44. Does coming to this drop-in centre help you to connect with other services and programs?
    - □ Yes
    - □ No
    - □ Unsure
    - □ Not applicable

45. What do you like most about this drop-in centre? Please tick all that apply.
    - □ Something to do
    - □ It gets me out of the house
    - □ Meeting people/making friends
    - □ Getting support
    - □ Help to access other services
    - □ Provides an opportunity to be with people who have similar issues
    - □ I can be anonymous if I want
    - □ Other (please specify)……

46. Over the past year, which of the following services or supports have you used? Please indicate if this drop-in centre provided the service or if it referred you to the service; or if this centre was not involved in obtaining the service.

	TYPE OF SERVICE	*I used the service provided by this drop-in centre*	*This centre referred me to a different (name of agency) site to provide the service [option not used for SMHOW]*	*This centre referred me to another agency that provided the service*	*This centre was not involved in obtaining the service that I used*
1	Homelessness services				
2	Housing – including crisis and supported accommodation				
3	Crisis response and referral including emergency relief				
4	Employment services				
5	Training and education				
6	Family violence				
7	Centrelink				
8	Child protection				
9	Family and child support				
10	Sexual diversity support				
11	Nursing				
12	Optometry				
13	Dental				
14	Podiatry				

15	Emergency department at a public hospital				
16	Mental health				
17	Emergency psychiatric service at a public hospital				
18	Other health services not listed here				
19	Disability support				
20	Drug and alcohol				
21	Aged care				
22	Legal aid				
23	Financial counselling				
24	Meals / Nutrition Program				
25	Sports				
26	Planned Activity Groups				
27	Volunteering				
28	Mentoring				
29	Pastoral care				

47. Over the past four weeks were there any services that you needed which were not available to you or you could not use for any reason?

    □ Yes □ No

48. If you answered 'Yes' to Q47, what were the services you needed, and why were you unable to use them?

    ……..

49. Do you participate in any of the following activities outside of a drop-in centre?

Activity	*Never*	*Rarely*	*Sometimes*	*Often*
Church group	☐	☐	☐	☐
Sport group or gym membership	☐	☐	☐	☐
Choir	☐	☐	☐	☐
Other community or social group	☐	☐	☐	☐
Music venues, live shows	☐	☐	☐	☐
Libraries, museums, art galleries	☐	☐	☐	☐
Volunteering	☐	☐	☐	☐
Other: …….	☐	☐	☐	☐

50. As a result of attending this drop-in centre, would you say there has been positive change for you in any of these areas? Please tick all that apply to you.

[Health and well-being]

□ Eat better

□ Better address my physical health needs

□ More able to manage my emotional and mental health

□ Less problematic drug and/or alcohol use

□ Increased participation in healthy activities

[Independence]

□ Learn new skills for getting through life

□ Do day-to-day tasks more easily

□ Know how to go about accessing the help I need

□ More confident in my ability to make better decisions

[Housing]

□ Have a better place to live

□ Have a safer place to live

□ Have a more affordable place to live

□ Better able to manage my tenancy

□ Transition to housing more suited to my needs

[Social and civic participation]

□ Make new friends

□ Get involved in social or leisure activities

□ Feel more part of the community

□ Reconnect with my family/my children

□ Enrol to vote

[Economic participation]

□ Get involved in training, volunteering or work

□ Obtain ID

□ Obtain my own bank account

□ Resolving outstanding debts and/or fines

□ Better able to manage my money

51. Do you have any other comments you would like to make about this drop-in centre?

……..

"If this survey has raised any issues that you would like to discuss with someone, please talk to a member of staff."

52. Do you feel that you need to talk to someone because of this survey?

□ Yes □ No

Thank you for your time and participation in the survey.

Appendix 3

Survey data tables

Q4 How old are you?						
Age	OCC	PM	SHM	SMHOW	All centres	% responses
18-24			6		6	1.22
25-44	36	24	74	20	154	31.24
45-64	53	54	94	56	257	52.13
65 or over	9	17	26	24	76	15.42
Total	98	95	200	100	493	100.00

Q5 What is your gender?						
Gender	OCC	PM	SHM	SMHOW	All centres	% responses
Male	87	76	134	67	364	73.83
Female	11	19	65	33	128	25.96
Other			1		1	0.20
Total	98	95	200	100	493	100.00

Q6 Where were you born?						
Country of birth	OCC	PM	SHM	SMHOW	All centres	% responses
Australia	77	71	153	55	356	72.21
Other	23	23	46	45	137	27.79
Total	100	94	199	100	493	100.00

Q7 Are you of Aboriginal or Torres Strait Islander origin?						
	OCC	PM	SHM	SMHOW	All centres	% responses
Neither	86	83	190	93	452	92.62
Aboriginal	11	7	6	7	31	6.35
Torres Strait Islander	1				1	0.20
Both Aboriginal and Torres Strait Islander		1	3		4	0.82
Total	98	91	199	100	488	100.00

Q8 Is English your main language?						
	OCC	PM	SHM	SMHOW	All centres	% responses
Yes	93	86	187	74	440	90.53
No	4	6	10	26	46	9.47
Total	97	92	197	100	486	100.00

Q10 What is your education level?						
	OCC	PM	SHM	SMHOW	All centres	% responses
Don't know	4	8	9	3	24	4.92
Primary school	5	6	13	4	28	5.74
Secondary/High school	70	61	116	60	307	62.91
Trade or technical qualification/ TAFE	11	10	32	15	68	13.93
University degree or equivalent	8	10	26	17	61	12.50
Total	98	95	196	99	488	100.00

Q11 What best describes your current living arrangements?						
	OCC	PM	SHM	SMHOW	All centres	% responses
Living alone	68	72	152	63	355	72.75
Living with others	23	12	30	9	74	15.16
Living with your partner/family members/people you feel close to	8	6	17	28	59	12.09
Total	99	90	199	100	488	100.00

Q12 Do you care for any dependent persons?						
	OCC	PM	SHM	SMHOW	All centres	% responses
No	90	85	169	73	417	87.79
Yes	7	8	22	21	58	12.21
Total	97	93	191	94	475	100.00

Q14 What are your sources of income? Please tick all that apply.							
Values	OCC	PM	SHM	SMHOW	All centres	% responses	% sample
No income	5	1	6	2	14	2.79	2.82
Own wage	3		3	2	8	1.60	1.61
Spouse / partner's income	1	1	1		3	0.60	0.60
Centrelink	90	93	188	93	464	92.61	93.55
DVA Pension			2	4	6	1.20	1.21
Other	1	1	3	1	6	1.20	1.21
Total	100	96	203	102	501		

Q15 If you are receiving Centrelink payments, which ones are they?		
	Total	% of sample
Newstart	113	22.78
Disability Pension (DSP)	284	57.26
Age Pension	64	12.90

Austudy	1	0.20
Abstudy	1	0.20

Q16 Are you currently looking for work?						
	OCC	PM	SHM	SMHOW	All centres	% responses
No	61	79	137	83	360	73.02
Yes	38	16	62	17	133	26.98
Total	99	95	199	100	493	100.00

Q17 If you answered Yes to Q16, what methods are you using to find work? Please tick all that apply.			
Employment services	Word of mouth	Jobseeking websites	Total responses
71	67	54	192

Q18 During the past six months have debts got in the way of meeting your basic needs, such as buying food, paying for transport, accommodation or other bills?						
	OCC	PM	SHM	SMHOW	All centres	% responses
No	33	51	72	38	194	39.19
Yes sometimes	27	14	54	36	131	26.46
Yes often	40	30	74	26	170	34.34
Total	100	95	200	100	495	100.00

Q19 Which of these best describes your current accommodation?						
	OCC	PM	SHM	SMHOW	All centres	% responses
Caravan park			1		1	0.20
Community rooming house – self-contained	5	8	19	8	40	8.08
Community rooming house – shared facilities	8	11	16	6	41	8.28
Crisis accommodation	1		3		4	0.81
Other (please specify)	6	3	8	5	22	4.44
Own home	2	5	1		8	1.62
Private rental	2	14	17	10	43	8.69
Private rooming house – self-contained	6	2	10	2	20	4.04
Private rooming house – shared facilities	4	8	25	1	38	7.68
Public housing – long-term	31	34	37	56	158	31.92
Sleeping rough, e.g. squat, street, car	25	6	48	9	88	17.78

Staying with friends/couchsurfing	2		8	2	12	2.42
Supported Residential Service	4	2	4		10	2.02
THM – Transitional Housing	4		4	1	9	1.82
YWCA Hostel		1			1	0.20
Total	100	94	201	100	495	100.00

Q21 Do you feel safe where you currently live?						
	OCC	PM	SHM	SMHOW	All centres	% responses
No	22	17	53	12	104	21.18
Yes moderately safe	34	26	60	39	159	32.38
Yes very safe	44	51	84	49	228	46.44
Total	100	94	197	100	491	100.00

Q22 Are the services and facilities that you need easy to get to from where you currently live?						
	OCC	PM	SHM	SMHOW	All centres	% responses
No	12	6	28	10	56	11.64
Yes moderately easy	29	14	39	17	99	20.58
Yes very easy	57	71	126	72	326	67.78
Total	98	91	193	99	481	100

Q23 Are you able to connect with friends and family from where you currently live?						
	OCC	PM	SHM	SMHOW	All centres	% responses
No	34	21	80	32	167	34.58
Yes sometimes	39	30	54	31	154	31.88
Yes often	25	42	60	35	162	33.54
Total	98	93	194	98	483	100.00

Q24 Do you feel part of your local community where you currently live?						
Row Labels	OCC	PM	SHM	SMHOW	All centres	% responses
No	48	35	73	22	178	36.03
Yes moderately	24	17	64	34	139	28.14
Yes very much	28	43	62	44	177	35.83
Total	100	95	199	100	494	100.00

Q25a Can you provide an estimate of how many times you have shifted accommodation in the past six months?						
	OCC	PM	SHM	SMHOW	All centres	% responses
Not at all	48	64	95	75	282	59.49
1 to 5 times	31	17	67	16	131	27.64
6 to 10 times	9	3	13	2	27	5.70

11 to 20 times	4	3	8	3	18	3.80
21 to 30 times	3		3		6	1.27
More than 30 times	2	2	6		10	2.11
Total	97	89	192	96	474	100.00

Q25b Can you provide an estimate of how many times you have shifted accommodation in the past five years?						
	OCC	PM	SHM	SMHOW	All centres	% responses
Not at all	32	40	45	56	173	37.20
1 to 5 times	21	29	64	28	142	30.54
6 to 10 times	18	11	33	5	67	14.41
11 to 20 times	13	3	18	1	35	7.53
21 to 30 times	2		4		6	1.29
More than 30 times	9	5	20	8	42	9.03
Total	95	88	184	98	465	100.00

Q26 Are you now or have you ever been homeless?						
	OCC	PM	SHM	SMHOW	All centres	% sample
Yes currently	41	16	78	22	157	31.65
Yes in the past	47	53	93	47	240	48.39
No	12	26	30	31	99	19.96
Total	100	95	201	100	496	100.00

Q26 Gender analysis of ever been homeless			
Gender	Ever been homeless		
	No	Yes currently	Yes in the past
Female n=128	18.75	33.59	47.66
Male n=364	20.33	31.04	48.63

Q27 If you answered 'Yes currently' to Q26, how long has it been since you were living in permanent accommodation, say for more than two years in the same place? (Data cleaned to only include respondents who reported being homeless at time of interview)						
	OCC	PM	SHM	SMHOW	All centres	% responses
1 to 4 weeks	2		11	1	14	9.27
1 to 6 months	7	4	11	1	23	15.23
6 months to 1 year	4		8	1	13	8.61
1 to 5 years	10	8	19	10	47	31.13
More than 5 years	16	4	25	9	54	35.76
Total	39	16	74	22	151	100.00

Q28 During the past four weeks has your mental health stopped you from doing what you wanted to do or needed to do e.g. go to an appointment?						
	OCC	PM	SHM	SMHOW	All centres	% responses
No	47	49	93	55	244	50.31
Yes sometimes	22	25	48	33	128	26.39
Yes often	26	18	58	11	113	23.30
Total	95	92	199	99	485	100.00

Q29 Do you regard yourself as living with a mental health condition or mental illness of any type?						
	OCC	PM	SHM	SMHOW	All centres	% responses
No	40	33	91	43	207	42.24
Yes	59	61	106	57	283	57.76
Total	99	94	197	100	490	100.00

Q31 During the past four weeks has your physical health stopped you from doing what you wanted to do or needed to do e.g. climbing stairs, preparing a meal, day-to-day tasks?						
	OCC	PM	SHM	SMHOW	All centres	% responses
No	51	57	102	42	252	51.22
Yes sometimes	23	17	48	28	116	23.58
Yes often	25	19	50	30	124	25.20
Total	99	93	200	100	492	100.00

Q32 Do you regard yourself as living with chronic disease or chronic illness?						
	OCC	PM	SHM	SMHOW	All centres	% responses
No	48	47	113	53	261	53.59
Yes	51	48	83	44	226	46.41
Total	99	95	196	97	487	100.00

Q34 Are you able to see a doctor when you need to?						
	OCC	PM	SHM	SMHOW	All centres	% responses
Yes	84	83	178	85	430	87.22
No but I would like to see one whenever I need to	13	7	18	13	51	10.34
No I'm not interested	3	3	4	2	12	2.43
Total	100	93	200	100	493	100.00

Q35 During the past four weeks has alcohol or drug use stopped you from doing what you wanted to do or needed to do e.g. getting a meal, attending a program or appointment, going to work?

	OCC	PM	SHM	SMHOW	All centres	% responses
No	64	76	143	82	365	74.34
Yes sometimes	20	10	23	14	67	13.65
Yes often	16	6	33	4	59	12.02
Total	100	92	199	100	491	100.00

Q36 If you needed to talk to someone about a serious issue, who would you talk to?		
	Number of responses	% responses
Friend	149	17.78
Family member	96	11.46
Case manager/social worker	291	34.73
Counsellor or health professional	164	19.57
Religious person e.g. priest, nun	60	7.16
Don't know	20	2.39
I would not talk to anyone	40	4.77
Other	18	2.15
Total	838	100.00

Q37 For how long have you been attending this drop-in centre?						
	OCC	PM	SHM	SMHOW	All centres	% responses
Less than 1 year	20	11	41	8	80	16.19
1-5 years	29	29	62	28	148	29.96
6-10 years	21	18	40	19	98	19.84
More than 10 years	29	37	58	44	168	34.01
Total	99	95	201	99	494	100.00

Q37 Analysis of homelessness status by how long attending centre			
	% of homelessness status group		
How long attending centre	Never been homeless	Currently homeless	Homeless in the past
Less than 1 year	11.22	29.49	9.58
1-5 years	32.65	28.21	30.00
6-10 years	20.41	14.74	22.92
More than 10 years	35.71	27.56	37.50
	100.00	100.00	100.00

Q38 How often do you attend this drop-in centre?						
	OCC	PM	SHM	SMHOW	All centres	% responses
Daily	28	45	74	40	187	39.45
2 or 3 times a week	40	35	68	40	183	38.61
Weekly	10	6	19	12	47	9.92

Fortnightly	3	1	11	1	16	3.38
Monthly	1		7		8	1.69
Occasionally	10	2	17	4	33	6.96
Total	92	89	196	97	474	100.00

Q39 Do you also go to other drop-in centres such as the Indian Sisters, or St Peter's or St Mark's?						
	OCC	PM	SHM	SMHOW	All centres	% responses
No	48	58	102	39	247	50.51
Yes	52	35	95	60	242	49.49
Total	100	93	197	99	489	100.00

Q41 Which of the following reasons best describe why you use this drop-in centre? Please tick all that apply.		
		% responses
I'm homeless and need assistance to access housing	97	5.61
My housing is at immediate risk e.g. eviction	12	0.69
I am fleeing a family violence situation	11	0.64
To access women's services	54	3.12
I need support to remain living in my own home	51	2.95
I've moved into one of this agency's residential services	3	0.17
Assistance with physical health issues	116	6.71
Assistance with mental health issues	111	6.42
Assistance with alcohol or other drug issues	41	2.37
To access a group or volunteer program	81	4.68
For social connection, seeing people, meeting friends	282	16.30
For material and/or financial assistance or support	74	4.28
For meals	450	26.01
To use the facilities e.g. showers, laundry, computers and internet, phone charger	186	10.75
Referral to another service	127	7.34
Other	34	1.97
Total	1730	100.00

Q41 Analysis of reasons for using drop-in centre by gender				
	Female	% of women	Male	% of men
I'm homeless and need assistance to access housing	28	5.10	69	5.90
I am fleeing a family violence situation	9	1.64	2	0.17
To access women's services	54	9.84	0	0.00
My housing is at immediate risk e.g. eviction	5	0.91	7	0.60
I need support to remain living in my own home	17	3.10	33	2.82
To use the facilities e.g. showers, laundry, computers and internet, phone charger	51	9.29	134	11.46
I've moved into one of this agency's residential services	0	0.00	3	0.26
For material and/or financial assistance or support	31	5.65	43	3.68
For social connection, seeing people, meeting friends	82	14.94	197	16.85
Assistance with physical health issues	27	4.92	87	7.44
Assistance with mental health issues	30	5.46	80	6.84
Assistance with alcohol or other drug issues	12	2.19	29	2.48
To access a group or volunteer program	33	6.01	48	4.11
For meals	115	20.95	331	28.31
Referral to another service	44	8.01	83	7.10
Other	11	2.00	23	1.97
Total	549	100.00	1169	100.00

Q42 Is this drop-in centre a place where you feel accepted by others?						
	OCC	PM	SHM	SMHOW	All centres	% responses
Yes	88	82	170	90	430	87.76
Unsure	5	8	15	10	38	7.76
No	3	3	10		16	3.27
Not applicable		1	5		6	1.22
Total	96	94	200	100	490	100.00

Q43 Is this drop-in centre a place where you feel safe?						
	OCC	PM	SHM	SMHOW	All centres	% responses
Yes	88	86	177	90	441	89.63
Unsure	7	3	15	9	34	6.91
No	3	3	5		11	2.24
Not applicable	1	2	3		6	1.22
Total	99	94	200	99	492	100.00

Q43 Analysis of feeling safe at centre by gender										
	No		Unsure		Yes		Not applicable			
	count	% of gender	count	% of gender	count	% of gender	count	% of gender	Total count	% of gender
Female	3	2.36	11	8.66	111	87.40	2	1.57	127	100.00
Male	8	2.22	23	6.37	326	90.30	4	1.11	361	100.00

Q44 Does coming to this drop-in centre help you to connect with other services and programs?						
	OCC	PM	SHM	SMHOW	All centres	% responses
Yes	85	68	154	85	392	79.19
Unsure	1	11	20	8	40	8.08
No	12	15	15	5	47	9.49
Not applicable	2	1	11	2	16	3.23
Total	100	95	200	100	495	100.00

Q45 What do you like most about this drop-in centre? Please tick all that apply.		
		% responses
Something to do	332	14.98
It gets me out of the house	345	15.57
Meeting people/making friends	368	16.61
Getting support	355	16.02
Help to access other services	295	13.31
Provides an opportunity to be with people who have similar issues	272	12.27
I can be anonymous if I want	191	8.62
Other	58	2.62
Total	2216	100.00

Q46 Over the past year, which of the following services or supports have you used?					
	I used the service provided by this drop-in centre	This centre referred me to a different site of theirs to provide the service	This centre referred me to another agency that provided the service	This centre was not involved in obtaining the service that I used	*Totals*
Homelessness services	119	6	23	82	*230*
Housing – including crisis	63	7	24	81	*175*

and support					
Crisis response and referral including emergency relief	59	8	24	67	*158*
Employment services	17	1	5	77	*100*
Training and education	27	1	6	58	*92*
Family violence	9	4	5	58	*76*
Centrelink	95	5	9	108	*217*
Child protection	3	1	1	61	*66*
Family and child support	9	0	2	57	*68*
Sexual diversity support	0	2	0	56	*58*
Nursing	66	2	6	77	*151*
Optometry	85	13	6	66	*170*
Dental	88	7	22	81	*198*
Podiatry	51	7	9	74	*141*
Emergency department at a public hospital	20	1	12	91	*124*
Mental health	47	3	17	74	*141*
Emergency psychiatric service at a public hospital	11	1	4	72	*88*
Other health services not listed	24	3	10	70	*107*
Disability support	31	1	7	59	*98*
Drug and alcohol	33	2	9	61	*105*
Aged care	16	1	1	63	*81*
Legal aid	51	3	11	65	*130*
Financial counselling	31	2	3	51	*87*
Meals/Nutrition Program	381	3	7	28	*419*
Sports	81	4	7	42	*134*
Planned Activity Groups	142	4	6	39	*191*
Volunteering	60	2	6	54	*122*
Mentoring	25	1	3	47	*76*
Pastoral care	45	2	3	58	*108*
Total	1689	97	248	1877	3911

Q47 Over the past four weeks were there any services that you needed which were not available to you or you could not use for any reason?						
	OCC	PM	SHM	SMHOW	All centres	% responses
No	74	83	138	84	379	79.45
Yes	22	12	53	11	98	20.55
Total	96	95	191	95	477	100.00

Q49 Do you participate in any of the following activities outside of a drop-in centre?					
	Never	Rarely	Sometimes	Often	*Total*
Church group	285	21	75	55	*436*
Sport group or gym membership	330	12	30	48	*420*
Choir	375	2	13	14	*404*
Other community or social group	279	7	59	64	*409*
Music venues, live shows	298	18	75	21	*412*
Libraries, museums, art galleries	223	13	107	97	*440*
Volunteering	287	6	41	52	*386*
Total	2077	79	400	351	2907

Q50 As a result of attending this drop-in centre, would you say there has been positive change for you in any of these areas? Please tick all that apply to you.		
	number of responses	% of sample
Eat better	428	86.29
Better address my physical health needs	318	64.11
More able to manage my emotional and mental health	274	55.24
Less problematic drug and/or alcohol use	74	14.92
Increased participation in healthy activities	163	32.86
Learn new skills for getting through life	169	34.07
Do day-to-day tasks more easily	163	32.86
Know how to go about accessing the help I need	195	39.31
More confident in my ability to make better decisions	186	37.50
Have a better place to live	90	18.15
Have a safer place to live	94	18.95
Have a more affordable place to live	74	14.92
Better able to manage my tenancy	75	15.12
Transition to housing more suited to my needs	53	10.69
Make new friends	372	75.00
Get involved in social or leisure activities	213	42.94
Reconnect with my family / my children	60	12.10
Enrol to vote	51	10.28
Feel more part of the community	229	46.17
Get involved in training, volunteering or work	69	13.91
Obtain ID	39	7.86
Obtain my own bank account	20	4.03
Resolving outstanding debts and/or fines	53	10.69
Better able to manage my money	82	16.53
Total	3544	

Survey data free text responses

CENTRE	**Q6 Where were you born?**	country
SMHOW	Other	sherlenka
SMHOW	Other	Afgensten
SMHOW	Other	Argentina
SHM	Other	Asia
PM	Other	Britain
SMHOW	Other	CAMBODIA
SHM	Other	Canada
SHM	Other	Check
OCC	Other	China
OCC	Other	China
SHM	Other	China
SMHOW	Other	CHINA
SMHOW	Other	CHINA
SMHOW	Other	china
SMHOW	Other	CHINA
SMHOW	Other	CHINA
SMHOW	Other	CHINA
SMHOW	Other	China
SMHOW	Other	China
SMHOW	Other	China
SMHOW	Other	CHINA
SMHOW	Other	CHINA
SMHOW	Other	CHINA
SMHOW	Other	CHINA

SMHOW	Other	CHINA
SMHOW	Other	Chines
SHM	Other	Croatia
SMHOW	Other	CZECHOSLOVAKIA
SMHOW	Other	EAST TIMOR
OCC	Other	Egypt
OCC	Other	Egypt
SHM	Other	Egypt
OCC	Other	El Salvador
OCC	Other	El Salvadore
OCC	Other	England
OCC	Other	England
OCC	Other	England
PM	Other	England
PM	Other	England
SHM	Other	England
SHM	Other	England
SHM	Other	England
SHM	Other	England
SHM	Other	England
SHM	Other	England
SMHOW	Other	ENGLAND
PM	Other	English
SHM	Other	English
PM	Other	Ethiopia
SMHOW	Other	Fiji

SMHOW	Other	France
SHM	Other	Germany
SHM	Other	Germany
SHM	Other	Germany
SMHOW	Other	GREECE
SMHOW	Other	greek macedonian
SMHOW	Other	Hiungry
SHM	Other	Holland
OCC	Other	Hong Kong
OCC	Other	India
PM	Other	India
PM	Other	India
PM	Other	Iran
SMHOW	Other	Iran
SHM	Other	Iraq
SHM	Other	Ireland
SHM	Other	Irish
OCC	Other	Israel
SHM	Other	Itali
OCC	Other	Italy
SHM	Other	Italy
SHM	Other	Korea
PM	Other	Leberlon
SMHOW	Other	Mexico
SHM	Other	Neithlands
OCC	Other	New Zealand

OCC	Other	New Zealand
OCC	Other	New Zealand
OCC	Other	New Zealand
OCC	Other	New Zealand
OCC	Other	New Zealand
OCC	Other	New Zealand
PM	Other	New Zealand
PM	Other	New Zealand
PM	Other	New Zealand
PM	Other	New Zealand
PM	Other	New Zealand
SHM	Other	New Zealand
SHM	Other	New Zealand
SHM	Other	New Zealand
SHM	Other	New Zealand
SHM	Other	New Zealand
SHM	Other	New zealand
SMHOW	Other	NEW ZEALAND
SMHOW	Other	NEW ZEALAND
OCC	Other	New Zealand
PM	Other	New Zealand
SHM	Other	New zealand
PM	Other	New Zealda
SMHOW	Other	Not Sure
SHM	Other	Nth afica
SHM	Other	NZ

SHM	Other	Peru
SHM	Other	Philippines
SHM	Other	Phillipanes
SHM	Other	Philppines
SHM	Other	Png
PM	Other	Poland
SHM	Other	Polland
SHM	Other	Romania
PM	Other	Russia
SHM	Other	Russia
SHM	Other	Singapore
SMHOW	Other	South Africa
SHM	Other	South Africa
SHM	Other	South amecia
PM	Other	South Korea
SHM	Other	Temore
PM	Other	Tonga
SMHOW	Other	Turckey
PM	Other	Uk
SHM	Other	UK
SMHOW	Other	UK
PM	Other	Ukraine
OCC	Other	United kingdom
SMHOW	Other	UNITED KINGDOM
PM	Other	United stat s
SMHOW	Other	VIETNAM

SMHOW	Other	VIETNAM
SMHOW	Other	VIETNAM
SMHOW	Other	VIETNAM
SMHOW	Other	Vietnam
SMHOW	Other	VIETNAM
SMHOW	Other	Vietnam
SMHOW	Other	Vietnam
SMHOW	Other	VIETNAM
OCC	Other	Vietnman

CENTRE	**Q8 Is English your main language?**	**If you answered 'No' to Q8, what is your main language?**
SMHOW	Yes	Afgan
PM	No	Amharic
SHM	No	Arabic
SMHOW	No	CANTONESE
OCC		Cantonese
SMHOW	No	Chinese
SHM	No	Croatian
SMHOW	No	CZECH
PM		English
SMHOW	No	French
SHM	No	German
SMHOW	No	HAKKA

OCC	No	Italian
SHM	No	Italian
PM	No	Kannada
SHM	No	Korean
OCC	No	Maderine
SMHOW	No	MANDARIN
SMHOW	No	MANDARIN
SMHOW	No	MANDARIN
SMHOW	No	MANDARIN
SMHOW	No	Mandarin
SMHOW	No	Mandarin
SMHOW	No	MANDARIN
SMHOW	No	MANDARIN
SMHOW	No	MANDARIN
SMHOW	No	MANDARIN
SMHOW	No	MANDARIN
OCC		Mangerine
SMHOW	No	Manrien
SMHOW	Yes	Menderlin
PM	No	New Zealand, Maori
SMHOW	No	Persen
PM	No	Persian and arabic
SHM	Yes	Philippine
SHM	No	Pigin english
SHM	Yes	Polish

PM	No	Russion
OCC	No	Spanish
OCC	No	Spanish
SHM	No	Spanish
SMHOW	No	Spanish
SHM	No	Tagalog
PM	No	Tongan
SMHOW	Yes	Turkish
SMHOW	No	VIETNAMESE
SMHOW	No	VIETNAMESE
SMHOW	No	VIETNAMESE
SMHOW	No	VIETNAMESE
SMHOW	No	Vietnamese
SMHOW	No	vietnamese
SMHOW	No	Vietnamise

Q45 What do you like most about this drop-in centre? – Other
a lot of support and help with dealing with violence (attending court and doctors appointments), material aid
Access facilities and have a sleep and meals.
All types of support
Being engaged in other programs
Brekky. For fucks sake....Please cook the toast on BOTH sides. I not feel like a social fuckup if the toast was normal. A small detail but this is not Dublin 1965!!!!!!!!!
conradey

Familure
Food
Food
Food is good
food, breakfast, lunch, and are unable prepare meals at home
Foods good
For a meal and have a shower
Free meals
Friendl
fun activities
Getting out in fresh air
Good looking girls
Good meals
Helps me connect with other services And my pet makes people feel at ease
Home made meals
It's free
It's very relaxing
just for the facilities that after available example lunch breakfast showers
Like the food
Meals
Meals
Meals
Meals
Meals
Meals and catching up
Meals and connect with other services

Meals and keeps me oc
Meals and to use shower
Meals.
Meals. To use facilities
Nice staff
Nice staff
PLAY POOL, HAVE BREAKFAST
Social
Social connection
Somewhere to go when there's nowhere to go
Staff and play pool
Staff are friendly
Staff are friendly
Support my artistic activities
That it gives the chance to help and volunteer
The chef, he makes really great soups
The staff
The staff are genie
To come to a base provides footing
To get fit
To get something to eat
To meet a friend
To relaxed
To use facilities and meals.
To use showers
WORKERS ARE POLITE AND GOOD.

Q48 If you answered Yes to Q47, what were the services you needed and why were you unable to use them?
A massage
Accomodation low on funds
Accomodation low on funds
Anger management
ASSISTANCE FOR PRESCRIPTIONS, UTILITIES BILLS
asthma attack at home
Because I don't have a Centrelink number services won't help me.
Centrelink
Centrelink ,emergency housing
Centrelink on strikes
Centrelink, they wouldn't assist me with what I needed and said "that's the system"
Centre...no computers!
Close on holidays here
Closed down services in gardenvale
Clothing, don't have any here. Food vouchers, hard to get
COMPUTER SERVICES
Could not use computers
Couldn't get food vouchers because I was told I wasn't due to get one.
Couldn't use services because I wasn't in the catchment area
Dental- overbooked. And I had to go to an aboriginal health services
Dentist
Disability
Doctor Meds
Doctors

Doctors services
Doctors, no appointment availuability
Doctors. Had to be there by nine am and couldn't use after nine due to their rules
Due to drinking
Early intervention/advocate
Eligibility criteria, preventing access to all services
Emergency medical service, knocked back becaus they were busy. Rude receptionist Access Health.
Emergency relief as there was no duty worker today
Employment , facilities for washing
Family location (considered excludedness)
Famliey volice
FINANCIAL ASSISTANCE
Food , clothing, support,
For housing
General
Hearing test
Housing
Housing
housing support
Housing worker. Wasn't available to see me.
Housing...Transport (Financial support)
I couldn't handle the wait so I walked out.
I don't have an income and when I asked for $17 to get my photo Id I was there was no funding that was here at Oz Community. I then went to Salvos and they helped me.
I have no phone number
I keep getting told that they have no more funding for me.

I Need to get out of the house
I was drunk and couldn't get a blood test
I was told I wasn't suitable even though I was homeless
If not well can't get to the appointments
Interumm housing
Lack of support and neglection
Launch housing (St Kilda) said they couldn't help me with accomodation
Launch housing, said cant help me anymore because they paid two weeks for me to stay at the Gatwick
Legal advice
Legal Advocacy
Legal matter due to not going through with it
Medcail
Medical services housing
Mental health
Moving into my room
Music ever &art
N/a
Needed support and dental care and financial assistance
Needles aboriginal case workers
Nursing staff not available and no doctor available on the days that they are rostered on
On weekends , nothing is opened
Only one computer on sight to use and can be used by others
Pain relief at Alfred hospital due to my honest admission that I occasionally use Iv drugs. That ended up being the closest to torture I have ever endured. So fucking angry and resentful
Photograpth work
Public holiday

Public holiday I couldn't use the laundry
Rainbow connections not enough numbers so couldn't go
Resource room shm closed for days at a time due to under staffing. Lack of prior notice for clients
Salvation Army crisis accomodation
sing i was trap when i lost my keys
Soap in the toilet
Table tennis
Telephone room
There was no volunteers for the emergency relief at St Vincent de Pauls and I am always being advised that there never is every time I ring.
There were times when couldn't help provide service
There's no night time meals like this service available.
They were not in knowing nor supportive
To gateway
Too far from me
Too sick to go out
Transitional housing not available
Transportation
Understaffed facilities
Used up my food vouchers for the sixth month period
Wanted legal aid assistance was not able to access
Wanted to access Yoga activity twice but the instructor was not available. Wanted to access the haircutting service but missed it since it is only provided once per month. Would like to access second hand food services but don't know how to..
Was a public holiday